Printed: 05/11/2024 Form Approved OMB No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676052 NAME OF PROVIDER OR SUPPLIER Immanuel's Healthcare		(X2) MULTIPLE CONSTRUCTION A. Building B. Wing STREET ADDRESS, CITY, STATE, ZI 4515 Village Creek Rd Fort Worth, TX 76119	(X3) DATE SURVEY COMPLETED 08/17/2022 P CODE	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)			
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	etc.) that affect the resident. **NOTE- TERMS IN BRACKETS H Based on observation, interview ar when the resident had an injury an a significant change in the resident residents reviewed for resident right. The facility failed to consult Reside significant skin injury of large multiple facility applied a dry dressing to the and the blistering had tripled in size Resident #1 became unresponsive and a UTI. This failure could place residents a timely, resulting in a delay in medic including death. On 08/16/22 an Immediate Jeoparremained out of compliance at a set that is not Immediate Jeopardy with	esident's doctor, and a family member of the AVE BEEN EDITED TO PROTECT Condition of the potential for requiring physical of the potential for requiring physicals physical, mental or psychosocial stants. The sents #1's physician when he was discovered by the blistering and skin coming off over the injury. Twenty-four hours later, the dresh and the physician was notified. While the At the ER, he was diagnosed with a 2 strict risk of not having their physician constal intervention and decline in health or doctors. While the IJ was exertify level of no actual harm with potential ascope of isolated due to the facility of their plan of removal. The facility Administration of the plan of removal of the plan of	ONFIDENTIALITY** 33552 onsult the resident's physician, al intervention and when there was tus for one (Resident #1) of five vered to have a sudden and the entirety of his left hand. The essing was noted to be weeping waiting for transport to the ER, 2nd degree thermal burn, sepsis sulted of changes in condition possible worsening of symptoms, removed on 08/17/22, the facility ential for more than minimal harm continuing to monitor the	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/17/2022
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	ion)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	admitted to the facility originally on diagnoses included non-Alzheimer person's kidneys cease functioning long-term dialysis or a kidney trans hyperlipidemia (a high level of fat pencephalopathy (a broad term for a (difficulty swallowing foods or liquic others and was rarely/never able to impaired cognitive skills for daily de and disorganized thinking. Resider rejection of care. Resident #1's req transfers, dressing, locomotion in hmotion impairment in his lower extrinterview; the staff pain assessment assessment period. Review of Resident #1's care plan related to immobility and incontiner blisters or discoloration. Interventio breakdown, notifying the nurse immidiscoloration noted during bath or cresults to MD and follow up as indicated to the second over left finger areas. Ha and left voicemail for RP. There we review of Resident #1's nursing not service over left finger areas. Ha and left voicemail for RP. There we review of Resident #1's nursing not while doing rounds at the end of slightly wet so nurse unwrapped it noted existing rosy, red area to top drainage however noted to this are filled blisters around existing area, his hand. When nurse asked reside to transfer to ER for further eval an resident's paperwork while resident	MDS assessment dated [DATE], reflect 12/08/17 and readmitted on [DATE] for 's dementia, end-stage renal disease (g on a permanent basis leading to the naplant to maintain life), hypertension (his particles in the blood, malnutrition, anxious prain disease that alters brain functions. Resident #1 had unclear speech, we understand others and his vision was ecision-making, signs and symptoms or the #1 had no indicators of psychosis, very purification of the premities on both sides. Resident #1 want indicated he did not have any indicated (undated) reflected he had the potential rece with a goal of, [Resident #1] will have any indicated to follow facility protocols for mediately of any new areas of skin breadcare, and obtain and monitor lab/diagnocated. The swritten by LVN A on 07/24/22 at 55 are notified nurse of skin issues. On top of the protocol of	om an acute hospital. His active a medical condition in which a leed for a regular course of gh blood pressure), diabetes, ety disorder, depression, tion or structure) and dysphagia was rarely/never understood by highly impaired. He had severely f delirium which included inattention erbal or physical behaviors or one or more staff for bed mobility, ersonal hygiene and had range of sunable to complete a pain ors of possible pain during the all for alteration in skin integrity we intact skin, free of redness, for the prevention, treatment of skin ekdown: redness, blisters, bruises, ostic work as ordered. Report 1.52 AM reflected, While getting of resident's left hand was cluster of its left hand. Other smaller blisters ing and wound care notified. Called der for treatment to his left hand. 1.53 AM written by LVN A reflected, th, dressing to left hand appeared dressing was taken off, this nurse est open the morning before. No noted multiple huge new clear fluid to large blisters on the left palm of otified immediately and order given intagious issues. While gathering ident noted to become verbally

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Fort Worth, TX 76119			
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	IENCIES full regulatory or LSC identifying informati	on)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety	Review of SBAR (Situation, Background, Assessment, Recommendation) Form completed 07/25/22 at 07:30 AM reflected Resident #1 had a change in condition that started on 07/24/22 and had multiple huge fluid filled blisters to left hand and while awaiting transport to the ER, he became verbally unresponsive. His blood pressure at the time of the SBAR was 94/53 and his pulse was 75.		
Residents Affected - Few	extreme response to an infection) a was re-wrapping it to do wound car blistering to the front and back dow giant open area to the back of the real to all four digits and thumb on the orissues beyond the left hand. The Redementia and previous stokes and care RN said the hospital was concalled the facility and spoke initially have any further information. Then The critical care RN said, Anyone of should have been a wet dressing. Seesentially it would stick to the wou asked the DON why they chose the nurse. The critical care RN said, I doloions, hot water exposure and she aide, so that is the note that was re the burn, the DON replied that she RN said, My thing is he won't even The critical care RN said, He came RN said she felt Resident #1 had a injury that he could do to himself. Review of Resident #1's hospital re 07/25/22 at 8:06 AM and was tachy	posed with second degree burns to his I and a UTI. The RN said when she first is e. He had blistering and a large open to in to where the wrist started. His skin on and that was red and granulated (havintide and palm side of the hand. She in said Resident #1 was unable to tell It baseline of confusion with mumbling of the baseline of confusion with mumbling of the properties. The properties are the DON called her 30 minutes later and the DON called her 30 minutes later and the properties. The properties are the properties and the properties and the properties and the properties are the properties. The properties are the properties are the properties and the properties are the properties. The properties are the properties are the properties are the properties and the properties are the properties are the properties. The properties are the properties. The properties are the properties. The properties are the prope	saw Resident #1's left hand, she to the back of his left hand and in the left hand was blistered with a ng a roughened surface), blistering said there were no more skin her what happened, and he had finappropriate words. The critical acted and immobile. She said she ursing progress note and did not and did not believe it was a burn. Sing which was not appropriate, it a burn such as Resident #1's, . The critical care RN said she bey had notified the wound care and asked if he had any new oils or iddle of the night on the 24th by an e said when she told the DON about in, and he said no. The critical care is not going to do this to himself. The critical care uspicious because it was not an atlal emergency department on ininute) to 170's, blisters and loss of
	epithelial skin (the tissue which cov corresponding area on the top part extremities were contracted. The E elevated heart rate, was reported the process. The ED medical doctor's f contractions of the atria make the v presence of blood in a person's urin	ers the internal and external surfaces of the hand) of the left hand consistent D's attending note stated, Patient was not yesterday he sustained some bliste inal impression/diagnosis was, Atrial fil rentricles beat too quickly), urinary trache), site unspecified, pneumonia of right request was made for wound care to	of the body) on the dorsum (the with possible burns and his upper sent from a nursing home for rs on his hand from an unknown orillation with RVR (when the rapid t infection with hematuria (the at lung to infectious organism,
	(continued on next page)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/17/2022
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	to the ED in atrial fibrillation and was threatening medical emergency) wis to the body, causing an increase in He was unable to provide a history the hand) blisters superior to the pagroup of small bones that comprise fingertip and over middle phalanx (a hand with absent epidermis (skin) sincluding tubular bulla of dorsal 1st st webspace, several small bullae phalanx. He was noted to be neuro plan by the MD was Wound care to changes liberal bacitracin ointment elevated on pillow. Five photos wer consult. An interview with the overnight nurs facility Saturday 2pm-10pm and the overnight shift 10 PM-6 AM. LVN A overnight shift 10 PM-6 AM. LVN A overnight shift was over Sunday me his skin and she wanted LVN A to I blister right on top of his hand that I draining. She said the skin was stil dry dressing and put it on the 24 hc LVN A said she did not contact MD Resident #1's left hand injuries bec just cleaned it and wanted the woun normally work the weekends and the alert the oncoming nurse to follow the early morning before the wounct that day for her overnight shift (Sun looked at the dressing, it looked like the amount of new blisters around it so the blisters tripled in numbers in cleaned it, wrapped his hand with a as I know, there was nothing that he and told him about it for the first to	stic surgery consult at the hospital date is found to be septic (the body's extrement has thermal injury (occurs when energy the temperature of local tissue) with blue to his dementia. Resident #1 was almar crease; blisters of [NAME] 5th digit the bony core of the digits (fingers) of a bone of the finger); 2) 2nd degree buseveral bullae (large blisters on the skir webspace, hemorrhagic blister (when over proximal (situated near) 4th and slogical confused and unable follow confunue management of burn per progradaptic/xeroform, ABD pad and loose to taken of Resident #1's left hand by the experiment of the confunction of the confunctio	ne response to an infection-life y is transferred from a heat source isters on his left hand and fingers. assessed as, 1) 2 Palmar (palm of git (finger) over phalanges (the the hand), blister on 4th digit rns of the dorsal (top) wrist and in that are filled with clear fluid) blood pools and forms a blister) in 5th digit, bulla of 4th digit middle nmands or provide history. The tocol; recommend daily dressing Kerlix wrap and to keep hand he hospital at the time of the vealed she had worked at the day (07/24/22) she worked the early morning hours before the titing him up and noticed issues with in, Resident #1 initially had a big t that had not popped but one was y rub it and she covered it with a they left him in bed at that time. 4/22 when she first noticed he look at it first. LVN A said she in. She said the wound nurse did not shour report to remind herself and as sent out to the ER the next day in the LVN A came back to work later she was rounding and when she she unwrapped it, there were triple which were not there the day before of his hand. LVN A said she ing her what to do. She said, As far wing. At that point, she called MD a dermatologist, but then said to

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	PEFICIENCIES and by full regulatory or LSC identifying information)		
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	physician to have he/she assess R out to the hospital. She also stated she believed MD E was notified ab LVN A. The DON said she was at the needed to swab residents for COV E. However, the DON said she did to see what his orders were. She she did not call him. The DON said 7AM and when she went to his roo had no indicators of pain and there she did not tell LVN A to contact the An observation and attempted interphysical room. Resident #1's eyes of questions. Upon increasing the volumestions were minimal, with only realing. There were no more liquid blisters were and on his palm of his had grown back over the top of his There were no open areas noted. The poured on top of his hand and it had palm, but since she was not preser Review of the facility's policy titled, 2013, reflected, The nurse should refer the things of the facility with significating infinity in the professional judgement deem physician immediately with significating record; .3. The nurse is respected in monitor and reassess the develop a working diagnosis and gif the resident's condition does not On 08/16/22 an Immediate Jeopard remained out of compliance at a seminimal harm that is not Immediate the implementation and effectivenest template on 08/16/22 at 2:21 PM.	8/22 at 2:26 PM revealed the facility die esident #1's left hand injury because the there was no wound care nurse working out Resident #1 on Sunday 07/24/22 phe facility that day, arriving early in the ID-19 due to a recent positive case. Shoot verify that LVN A called him and diaid she had just assumed LVN A called is he first saw Resident #1' hand when m, she saw the blisters on his left hand was no other issues with his skin othere doctor (MD E) and had assumed she review of Resident #1 occurred on 08/15 were closed but he was awake. He was ume of the voice, he stirred and moved making a sound each time, no discernate unwrapped his left hand to proceed with or sounds of discomfort. His left hand and in the hand, however, it was lighter in color to the hospital RN said it looked like Resid dripped down and around through him to observe the injury happen, she was not he he sitate to contact the physician at it necessary for immediate medical attement change in status. The nurse will don't he ophysician, and interventions that we ponsible, however, for responding to a cument the time of the call to the physic eresident's status and response to interventions that we ponsible, however, for responding to a cument the time of the call to the physic eresident's status and response to interventions that we ponsible, however, for responding to a cument the time of the call to the physic eresident's status and response to interventions that we ponsible, however, for responding to a cument the time of the call to the physic eresident's status and response to interventions that we provide the nursing staff in what to monito improve. Add (IJ) was identified. While the IJ was everity level of severity level of no actual exponential exponen	the resident had already been senting on the weekend. The DON said frior to her arriving at the facility by morning around 6am because she e said thought LVN A notified MD don't follow up with her afterwards of MD E and she had no idea why she arrived that morning around a before they erupted. She said her than his left hand. The DON said had already done that. 6/22 at 3:30 PM while he was in his is initially not responsive to this head, but his responses to oble words. His blood pressure was head ressing change. Resident #1 was observed to be in a state of easeen on his knuckles where the new being of his fingers. The skin man the other surrounding skin. In dent #1 may of had something hot is fingers to the underside of his is only speculating. Change in Status revised March any time when an assessment and the ention; 1. The nurse will notify the cument signs and symptoms of the ere implemented in the resident's change in condition in a timely and ician in the clinical record; 6. The removed on 08/17/22, the facility all harm with potential for more than to the facility continuing to monitor Administrator received the IJ	

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(X4) ID PREFIX TAG		RY STATEMENT OF DEFICIENCIES ficiency must be preceded by full regulatory or LSC identifying information)		
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[Facility Name-Plan of Removal 8/* 1. F580 - Failure to Notify Physicia Resident #1 was found with a char with skin on top gone) on Sunday (care. He was assessed by the DOI condition and put a dry bandage or treatment orders were not obtained blisters had tripled in size. Doctor rand found to have 2nd degree ther hand, UTI and sepsis. Noted: Resident #1 cognitive status without Behavioral Disturbances. Fable's which include dressing, bath [CNA D] reported to [LVN A] of the A skin sweep was performed by [R residents with dryness to bilateral litreatments. Responsible Parties were clinical Compliance Nurse [CC-RN-On 8/16/2022, a re-education of icand how they can occur; notifying pskin alteration/ skin injuries, failure state guidelines to the appropriate causes of the injury to the Director On 8/16/2022, a re-education of icand how they can occur; notifying pskin alterations and state guidelines to including potential causes of the injury to the Director of Nursing/Designee will: - Complete a skin assessment on condition of the complete as kin assessment on condition of the complete ask	nge in condition to his left hand (blistere o7/24/22 in the early morning hours by N and LVN promptly who felt he did not his hand. The physician was not notifed at that time. Next morning, Resident # notified at that time and sent resident to mal (which means burn came from extending a dispersion of the contractures, and his co	ed all over top and bottom of hand a CNA when doing incontinent have a burn, but a change in skin ied of the change in condition and £1's dressing was removed, and ER. At hospital, resident evaluated ernal heat source) burns to his left agnosis of Unspecified Dementia are needs are total dependence for dimobility, and wheelchair mobility. 2 and the nurses' identified in E1 to notify and obtained orders for remover types of burns; thermal burns cols to obtain treatment orders for roding to federal regulations and unknown origins including potential ferent types of burns; and notifying inknown origin according to federal pating injuries of unknown origins sk management protocol. Risk cian, executing physician orders	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	protocols to obtain treatment order. Any staff member not receiving the An employee roster and schedule with new hires, and agency nurses will be addressed at the Performance Improvement monthly. Facility Designee or Administrator Performance Improvement (QAPI) Monitoring interviews for the Immethrough 08/17/22 at 4:30 with 15 stinursing, administration, dietary and related to change of condition, injurcan occur, notification to the physic (showers)/liquids (drinks) parameter. Additionally, the Corporate Regiona 08/17/22 related to thermal burn id treatment orders, recognizing a chareporting injuries of unknown origin. The following staff's in-service logs the monitoring time frame and were related to change of condition, injurthermal burn injuries and how they abuse and neglect, and hot water (BOM, CNA K, LVN B, Cook L, Lau Monitoring and review of all residents were remained after pressure reduction, open ulcers, dry or flaky skin and eincluding burns. 19 residents were physician was notified, and an order and/or feet. The facility's ADM was notified the	diate Jeopardy were started on 08/17/2 aff across all three shifts, including we housekeeping departments. The staff ries of unknown origin, notification to Al cian, obtaining treatment orders, abuse ers. Staff were able to verbalize unders all Clinical RN provided an in-service do entification, intervention and notification range in condition, recognizing an injury to HHSC and investigating. and competency tests were reviewed e able to articulate what they had been ries of unknown origin, notification to Al could occur, notification to the physicia showers)/liquids (drinks) parameters: Condry Aide M, Med Aide N, LVN O, ADC and skin assessments completed by the re re checked for any changes to skin, to in rashes, bruises open lesions, cuts lace dema. No residents were found to have assessed as having dry and/or flaky sker was obtained for Eucerin (emollient) IJ was removed on 08/17/22 at 4:35 Pl s removed on 08/17/22, the facility remains	ated prior to next scheduled shift. Idiance. Facility per diem nurses, ing for duty. facility Quality Assurance Peporting to Quality Assurance and Peporting to Quality Assurance and Peporting to Quality Assurance and Pekdays and weekends, from the were interviewed about procedures DM, thermal injuries and how they and neglect, and hot water tanding of the training received. Per with the DON and ADM on to the physician, obtaining of unknown origin, as well as and they were interviewed during taught, protocols and procedures DM of injuries of unknown origin, an, obtaining treatment orders, CNA G, RN H, CNA I, Hkpg J, DN P, MDS RN F, ADM and DON. facility nurses on 08/16/22 and include reddened areas that terations and skin tears, blisters, e any injuries of unknown origin, kin. For those residents, the for bilateral lower extremities M.

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F 0607	Develop and implement policies an	nd procedures to prevent abuse, neglec	t, and theft.
Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS IN Based on observation, interview, an policies and procedures that prohib policies and procedures to investig for abuse, neglect, and exploitation. The facility staff failed to investigate to have a significant injury to his lef #1 had to be sent to the ER the foll size, where he was diagnosed with tract infection. The hospital notified The facility abuse/neglect coordina. This failure could place the resident abuse, neglect, and injuries of unknown of the properties of the properti	HAVE BEEN EDITED TO PROTECT CO and record review, the facility failed to de bit and prevent abuse, neglect, and exp ate any such allegations for one (Reside an injury of unknown origin of Reside ft hand, and whose source could not be owing day when he became unrespons a second degree thermal burns to his with the facility that there was a concern the tor did not initiate an provider investigates	evelop and implement written loitation of residents and establish lent #1 when the resident was found exidentified by the facility. Resident sive and the blisters had tripled in hole left hand, sepsis and a urinary at the resident had been burned. The to uninvestigated allegations of the total allegations of the total allegations of the total or structure) and dysphagia as rarely/never understood by highly impaired. He had severely delirium which included inattention roal or physical behaviors or one or more staff for bed mobility, rsonal hygiene and had range of the unable to complete a pain
	assessment period. (continued on next page)		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)	
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's care plan (undated) reflected he had the potential for alteration in skin integrity related to immobility and incontinence with a goal of, [Resident #1] will have intact skin, free of redness, blisters or discoloration. Interventions included to follow facility protocols for the prevention, treatment of ski breakdown, notifying the nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, discoloration noted during bath or care, and obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Review of Resident #1's nursing notes written by LVN A on 07/24/22 at 5:52 AM reflected, While getting			
	blisters, with the biggest one obser observed over left finger areas. Ha and left voicemail for RP. Review of Resident #1's nursing now While doing rounds at the end of stalightly wet so nurse unwrapped it noted existing rosy, red area to top drainage however noted to this are filled blisters around existing area, his hand. When nurse asked reside to transfer to ER for further eval an resident's paperwork while resident unresponsive despite being given to Review of the facility's incident and Review of SBAR (Situation, Backgrand AM reflected Resident #1 had a children and sale in the side of the si	e notified nurse of skin issues. On top of ved to have opened up on the top of hind cleaned and covered with dry dress on the step of hind cleaned and covered with dry dress on the step of hind cleaned and covered with dry dress on the step of hand where the first blister had burst a. To surrounding area was however non all left fingers and knuckles, and twent if he was in pain, he said no .MD not do to rule out any possible infections/co to was seated at the nurses' station, rest he sternal rub and was being shaken in accident logs for July 2022 revealed Fround, Assessment, Recommendation) ange in condition that started on 07/24, awaiting transport to the ER, he becandars 94/53 and his pulse was 75.	s left hand. Other smaller blisters ing and wound care notified. Called M.M. written by LVN A reflected, nt, dressing to left hand appeared dressing was taken off, this nurse st open the morning before. No oted multiple huge new clear fluid o large blisters on the left palm of otified immediately and order given intagious issues .While gathering ident noted to become verbally nany times. Resident #1 was not listed.	

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	IDER/SUPPLIER/CLIA ATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. Building	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER		B. Wing	08/17/2022	
NAME OF FROVIDER OR SOFFEIER		STREET ADDRESS, CITY, STATE, ZI	P CODE	
Immanuel's Healthcare		4515 Village Creek Rd	FCODE	
inimanuers ricalulcare		Fort Worth, TX 76119		
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.				
` '	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)			
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Residents Affected - Few Residents Affected - Few An interviet the hospita said when and a large started. His and granus there were happened inappropris contracted her a nurs later and of the night when she and if he hof the night when she and he sais is not goin made me suspicious Review of 07/25/22 a epithelial is corresponsextremities elevated his process. To contraction presence of unspecifie appearing.	w with the hospital critical and had been diagnosshe first saw Resident # e open to the back of his se skin on the left hand whated, blistering to all four no more skin issues beyond he had dementia and the words. The critical cand immobile. She saiding progress note and did not believe it was a build not he 24th by an aide, told the DON about the build do not he critical care RI go to do this to himself. The because it was not an interest was not an interest was not an interest was reported to the ED medical doctor's the ED medical doctor's the soft the atria make the worf blood in a person's urill	al care RN on -7/28/22 at 12:37 PM reveled with second degree burns to his left end with second degree burns to his left end with second degree burns to his left end with an and blistering to the front and as blistered with a giant open area to the digits and thumb on the outside and please of the RN said Reside and previous stokes and baseline of confider RN said the hospital was concerned she called the facility and spoke initialled not have any further information. The arm. The critical care RN said, I did tell the system of the provider of the hand and external surfaces of the hand) of the left hand consistent the provider of the hand of the left hand consistent the provider of the hand of the left hand consistent the provider of the hand of the left hand consistent the provider of the hand of the left hand consistent the provider of the hand of the left hand consistent the provider of the hand of the left hand consistent the provider of the hand of the left hand consistent the provider of the hand of the left hand consistent that yesterday he sustained some blister of the hand of the left hand consistent that yesterday he sustained some blister of the hand of the left hand consistent that yesterday he sustained some blister of the hand of the left hand consistent of the hand o	realed Resident #1 was presently at hand, sepsis and a UTI. The RN do wound care. He had blistering I back down to where the wrist he back of the hand that was red alm side of the hand. She said ant #1 was unable to tell her what fusion with mumbling of the because Resident #1 was ywith MDS RN F who only read in the DON called her 30 minutes he DON I thought it was a burn this was first noticed in the middle at This is pretty significant. She said and Resident #1 if he was in pain the property of the proof of the bad. It injury of unknown origin and it was all emergency department on an initial to 170's, blisters and loss of the body) on the dorsum (the province with possible burns and his upper sent from a nursing home for the son his hand from an unknown origination with RVR (when the rapid at infection with hematuria (the at lung to infectious organism,	

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 676052 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. Building B. Wing 08/17/2022	I			
		TION IDENTIFICATION NUMBER:	A. Building	COMPLETED
NAME OF DROMINED OR CURRILED			CTDEET ADDRESS OUT CTATE TO	ID 0005
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		RSUPPLIER		ID CODE
Immanuel's Healthcare 4515 Village Creek Rd Fort Worth, TX 76119	Immanuel's Healthcare			
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.	agency.			
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)	(X4) ID PREFIX TAG			ion)
Review of Resident #1's wound/plastic surgery consult at the hospital dated 07/26/22 reflected he present to the ED in atrial fibrillation and was found to be septic (the body's extreme response to an infection-life threatening medical emergency) with a thermal injury (occurs when energy is transferred from a heat sour to the body, causing an increase in the temperature of local tissue) with bisters on his left hand and finger He was unable to provide a history due to his dementia. Resident #1 was assessed as, 1, 2 Palmar (palm the hand) bilsters userior to the palmar crease; bilsters (INAME) fish digit (finger) over phalmages (the group of small bones that comprise the bony core of the digits (fingers) of the hand, bilster on 4th digit including toublar buils of dorsal 1st webspace, hemorrhagic bilster (when the dorsal (toy) wist and hand with absent epidermis (skin) several bullae (large bilsters on the skin that are filled with clear fluid) including tubular buils of dorsal 1st webspace, hemorrhagic bilster (when do pools and forms a bilster); 1st webspace, several small bullae over proximal (situated near) 4th and 5th digh, build of 4th digit middle phalanx. It was noted to be neurological confused and mabble follow commands or provide history. The plan by the MD was Wound care to continue management of burn per protocol; recommend daily dressing changes liberal beachrach in internal, adapticivatorform, ABD pad and loos kink warpa and to keep hand elevated on pillow. Five photos were taken of Resident #1's left hand by the hospital at the time of the consult. Review of TULIP database on 07/27/22 revealed no evidence of a provider investigation report or a provide investigation for Resident #1's injury of unknown origin.	Level of Harm - Immediate jeopardy to resident health or safety	Review of Resident #1's wound, to the ED in atrial fibrillation and threatening medical emergency to the body, causing an increase He was unable to provide a hist the hand) blisters superior to the group of small bones that comp fingertip and over middle phalar hand with absent epidermis (ski including tubular bulla of dorsal 1st webspace, several small bul phalanx. He was noted to be ne plan by the MD was Wound can changes liberal bacitracin ointm elevated on pillow. Five photos consult. Review of TULIP database on 0 investigation for Resident #1's in	plastic surgery consult at the hospital dat was found to be septic (the body's extrer with a thermal injury (occurs when energy in the temperature of local tissue) with a thermal injury (occurs when energy in the temperature of local tissue) with orry due to his dementia. Resident #1 was be palmar crease; blisters of [NAME] 5th disise the bony core of the digits (fingers) of x (a bone of the finger); 2) 2nd degree buth) several bullae (large blisters on the skill 1st webspace, hemorrhagic blister (when late over proximal (situated near) 4th and surological confused and unable follow core to continue management of burn per protect, adaptic/xeroform, ABD pad and loose were taken of Resident #1's left hand by the transport of the providence of a providence of	ed 07/26/22 reflected he presented me response to an infection-life by is transferred from a heat source disters on his left hand and fingers. It assessed as, 1) 2 Palmar (palm of git (finger) over phalanges (the fithe hand), blister on 4th digit turns of the dorsal (top) wrist and in that are filled with clear fluid) blood pools and forms a blister) in 5th digit, bulla of 4th digit middle mmands or provide history. The otocol; recommend daily dressing a Kerlix wrap and to keep hand the hospital at the time of the

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Immanuel's Healthcare 4515 Village Creek Rd Fort Worth, TX 76119			
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	his hand needed to be looked at by RN the day before (07/26/22) who called the hospital RN because of I abuse. The DON said she took a p out. She said his left hand was red thought maybe this was cellulitis. Sleft hand), I told [MD E] it was not p after being notified on Day 2 of the #1's hand. The DON said when she when Resident #1 was sent out for think. The DON said she did not kn interviewable and sometimes made DON said Resident #1 was not am and wheelchair bound. She said he burn would definitely be red and rawould be white with moisture assoc of the wound and it would be extremely what happened with Resident #1, I done because it was never anythin care nurse or doctor did not look at is not a burn because those blisters that were not related to burn. That fluid filled and were small and rapic them anything about what happened pain or tearfulness or guardedness. An interview with MDS RN F on 07 out what happened to Resident #1'	/27/22 at 3:15 PM revealed the hospita s hand and said his whole hand was b ogress notes to the hospital critical care	ad talked to the critical care hospital burned or abused. The DON then d told her it was a skin issue, not anday morning when he was sent ed. She said, Initially we had nowed her phone of Resident #1's did not visit Resident #1 in person sicture that she took of Resident d gotten on the second day, was felt it was some kind of infection, I at the hospital. She said he was not a pain, but he did not talk at all. The on ADLs and he was bed bound d family visitors. The DON said a and it, and around the edges it own fluid leaking out from the edge he way to 3rd degree. She said DON said an incident report was not ound or injury. She said a wound 24 hours. The DON said, I know it we seen fluid filled blisters like that, his body. She said the blisters were he said Resident #1 could not tell uli and he never presented with any

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
Evel of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	07/23/22 and 07/24/22 but did see was clear when she left work on Fr blister on the top of his left hand the was and no one could understand because something real hot would swollen and he had a blister on the normally could talk, but he was not get a reaction, but he was not resp pain. She said by that time, the over they wanted to do and MD F said to that, she googled burn blisters on the said, But I don't want to say it is a buful that an injury of unknown origin occurred She then said, We don't wanted to do and the was the last in the morning around 11 AM. but as the MOD, she went to each incidents and accidents and she was the last in the morning around 11 AM. but as the MOD, she went to each incidents and accidents and she was later helped serve dinner. She said aware of Resident #1's hand during already been sent out. MDS RN F.	22 at 10:51 AM revealed she did not see him when she arrived at work on Monoiday 07/22/22 but when she came back at had already busted and the night nu how he got blisters like that. LVN B sai have had to caused it. She said Reside pointer finger side going towards the tother at all, she shook him, called his conding, which was unusual. She said her prinight nurse (LVN A) had notified the formal seed of the prinight nurse (LVN A) had notified the formal seed of the hand and the pictures on the interned ourn, because that is not good. LVN B so she said that would be when a person show how this one occurred. Fon 07/28/22 at 11:17 AM revealed see RN manager on duty on Sunday 07/2 She said she had not been notified of a nurses' station, asked how things were as told no. She then went to the MDS of she did not see Resident #1's hand. Not get the morning management meeting or said an injury of unknown origin was so, the facility should look into what happen in the principal seed of the facility should look into what happen is the facility should	lay 07/25/22. LVN B said his skin on 07/25/22, he had one big ree (LVN A) was not sure what it d she did not know if it was a burn ent #1's index finger was really humb. LVN B said Resident #1 name and tried to open his eyes to be could not tell her if he was in DON and physician to see what thad happened. LVN B said after est looked like Resident #1's. LVN B said she did not know if Resident in could not tell how an injury when he had been employed at the 4/22 and had come to the facility any issues related to Resident #1 going, if there were any new office and did assessments and IDS RN F said she was first made a Monday 07/25/22, after he had benething that was abnormal, that

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/17/2022
NAME OF PROVIDER OR SUPPLIER Immanuel's Healthcare		STREET ADDRESS, CITY, STATE, ZI 4515 Village Creek Rd Fort Worth, TX 76119	P CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	facility Saturday 2pm-10pm and the overnight shift 10 PM-6 AM. LVN A overnight shift was over Sunday mhis skin and she wanted LVN A to blister right on top of his hand that draining. She said the skin was still dry dressing and put it on the 24 hc LVN A said she did not contact MD Resident #1's left hand injuries bedjust cleaned it and wanted the wou normally work the weekends and the later the oncoming nurse to follow the early morning before the wound that day for her overnight shift (Sur looked at the dressing, it looked lik the amount of new blisters around so the blisters tripled in numbers in cleaned it, wrapped his hand with a as I know, there was nothing that hE and told him about it for the first send Resident #1 to the ER in case don't know if he was reacting to an burn because no one had mentione with the wound wrapped up, I don't know how it occurred. Observation and record review of to 07/23/22 or 07/24/22 related to the An interview with the wound care Leant to been on her caseload and she mentioned anything to her about Remetioned anything to her about Reme	se, LVN A, on 07/28/22 at 11:56 AM rese overnight shift (07/23/22) and on Sun a said she was notified by a CNA in the borning (07/25/22) that the CNA was ge ook at it. When LVN A went to his roor had popped and little one right next to lon so she did not want to aggressively our report to remind herself. LVN A said in E or an on-call doctor on Sunday 07/2 ause the facility lets the treatment nurse and nurse to look at it when she came in nat was why she made a note in the 24 up. However, she said Resident #1 was do care nurse could look at his hand. When the entire hand, like big, huge blisters was a dry dressing and texted the DON asking a dry dressing and texted the DON asking a dry dressing and texted the DON asking burned him, but the wound was grown in the said initially he would refer to be he had something contagious since it bything or if he was burned. LVN A said and anything to her, But with the tripling know. LVN A said an injury of unknown the 24-hour book for Hall 100 (Resident resident. VN G on 07/28/22 at 07/28/22 at 3:10 did not work over the weekend on 07/2 esident #1's hand and he had already long the facility. Wound Care LVN G said a said there could be blistering, discolor be missing due to the degree of the build re-blister, pop on their own and cor	day (07/24/22) she worked the early morning hours before the ting him up and noticed issues with in, Resident #1 initially had a big it that had not popped but one was your it and she covered it with a different that time. 24/22 when she first noticed see look at it first. LVN A said she in. She said the wound nurse did not hour report to remind herself and is sent out to the ER the next day in the LVN A came back to work later she was rounding and when she she unwrapped it, there were triple which were not there the day before of his hand. LVN A said she ing her what to do. She said, As far wing. At that point, she called MD a dermatologist, but then said to came on that rapidly. LVN A said, I she did not initially think it was a of them (the blisters) the next day, in origin was when a person did not in the shear of the hospital by the bout it through hearing people burn could present differently, ation, redness, some swelling due in. She said most second degree

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NAME OF PROVIDER OR SUPPLIE	ER	STREET ADDRESS, CITY, STATE, ZI	P CODE
Immanuel's Healthcare		4515 Village Creek Rd Fort Worth, TX 76119	
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Evel of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	07/22/22 and his skin looked great, Monday morning 07/25/22, she wa CNA C said then the overnight nurs of his hand. She said she was won his hands balled up and only move looking like person who got burned and that he had blisters everywher because he was blind and only sport C said, I said y'all sure it not a burn what if this is your family member? sternal rub, But nothing, like he wa members off the schedule who had investigate, and she just looked at is looking into it. An interview with CNA D on 07/28/time on Resident #1's hall on Satur with him on another hall. She said he was quiet and she was worried She said he was a typically a heavy on him, he was dry up until 3:50 An not as much as it used to be could at all her shift until then. When she much and he was laying on his harbrown layer of something next to hi hand and saw the entire left layer oup his hand and he groaned when LVN A and asked what happened being in water too long but he was were huge blisters all over his hand unknowingly, so she told LVN A. Cor move his arms more than to his himself. She said LVN A wrapped hersident #1 did seem to be in pain hand up and started to wipe it down like LVN A was not being responsing of her before and pass away, so Remove, cannot do this to themselves she (LVN A) wrapped his hand too was like, just dry gauze on the ope her the rest of the shift and CNA D	22 at 12:25 PM revealed she had last so she could see his hands when she laid is told that he maybe had an infection be see. LVN A took off the dressing and she dering how that could have happened in the dering how the dering how the dering how had and he was not responding to the dering had been and they were like shhhhh (be quiet so she said when Resident #1 was not responding it. CNA C said she told the DO is worked with Resident #1 before that the dering had so she said, If it was my family members and the vernight shift, around 3:50 AM he was not breathing but then looked by soil and outputs a lot and the entire in the dering him to the dering him to the hook shutting down. So changed him, it was only urine and it of so she turned him over. When CNA him. She did not know what it was. She of skin on his left hand was missing. She lifted it up and it looked like he had be because it looked fresh because his fin African American. She said Resident #1 was severely inface, he was stuck in the fetal position his hand temporarily because there was no before it was wrapped, he was making we and CNA C was panicked because is esident #1's hand made her emotional. In the proof of the pool of th	d him down. When she saw him ecause his hand was wrapped. It is saw he had pink raw skin on top because Resident #1 always kept ed Resident #1's left hand as stion that took the skin off like that could not tell her what happened is ve, which was not normal. CNA ound). At the same time I was like esponding to her, she tried to do a N that she should take staff ime frame just in case, and her, I would want to know the facility do the overnight shift for the first but she knew him from working, she went in to check on him and loser and saw his chest was rising. Ight when she would go and check continence being not as frequent or he said Resident #1 had not voided could fill her palm so it was not C turned him over, there was a thin picked it up and then looked at this e said, I was like oh my god, I lifted the burned. CNA C then went to gers where white in color, like the had resident of his hand skin jured and he could not walk, see, and he could not have burned as puss on his hand. CNA C said and when she and LVN A pulled his go little groans. CNA D said she felt she had residents get hurt in front She said, Someone that cannot a sense of urgency or care. When a pad and wrapped it real quick. I CNA D said LVN A did not talk to the core and not wanting to work with

STATEMENT OF DEFICIENCIES (X1) P			
-	PROVIDER/SUPPLIER/CLIA TIFICATION NUMBER: 52	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/17/2022
NAME OF PROVIDED OF SUPPLIED			D CODE
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	CODE
Immanuel's Healthcare		4515 Village Creek Rd Fort Worth, TX 76119	
For information on the nursing home's plan to co	orrect this deficiency, please conf	act the nursing home or the state survey	agency.
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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Residents Affected - Few Residents Affected - Few A follo Sunda his har before than health or an injury was more than health or an injury was m	ow up interview with the DON ay, 07/24/22 around 7AM became they erupted. She said he have they erupted. She said he have they erupted. She said she have the DON said an injury of unsuch that the DON said an injury of unsuch the DON said an injury of unsuch that the DON said and injury of unsuch that the said she did not feel Resury. She claimed no one from not supposed to diagnose a really to MD E on Sunday 07/24/24/24/24/24/24/24/24/24/24/24/24/24/	on 07/28/22 at 2:26 PM revealed she fause she had to swab him to test for Cotified. When she went to his room, she ad no indicators of pain and there was the could not remember when she notificated to her that it was sident, they can describe the situation the hospital indicated to her that it was sident, they can describe Resident #1 and Neglect Coordinator because it prem know if he was in pain, and he was she had been notified from the hospital notified the ADM and it would be reported the said he vaguely remembered being asking him about the lesions he had was see in the facility so he wanted Resident her acondition. MD E said, If a resident had would have needed a description of the facility are looking at or seeing. Mon 07/25/22 and that was the reason hething an injury of unknown origin is they and could not identify any infections.	irist saw Resident #1's hand on OVID-19. LVN A had already seen a saw the blisters on his left hand no other issues with his skin other ed the ADM about Resident #1's e described as to where it came in, she felt it was an infection, not a burn. The DON said a nurse to the physician. She said she did skin change/injury to him, I alify to be called to HHSC as a esented as an infection and not, and a burn would be I that the resident had second red to HHSC and an investigation are call director for the facility and g contacted by the facility Monday which was a bug deal with Monkey number one on his list to watch out when the injury was first identified as big blisters all over his hand, they be lesions. He said, A lot of times, I in E said he remembered being the sent him out, when he saw it.

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AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/17/2022
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	ENT OF DEFICIENCIES be preceded by full regulatory or LSC identifying information)	
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	coordinator and she investigated al reported any suspicious injuries and process, the ADM said she may sush aid she was first told about Reside morning on 07/25/22. She told the was in, but the ADM could not so notified her about the injury on Sun ADM said the DON should have let stand-up meeting on Monday 07/25 out already and that he had some be diagnosis of whatever that is. The Alleft hand. The ADM said, I have new have a weak stomach. I will say I jublisters, I was like what is that? She diseases that when there is a flare out like that. The ADM stated, So I this was a reportable incident to Stateff about whether it was reportable. The ADM further said after the adm and the MDS RN F came to her and the ADM said she went to the DON. The ADM said she did not discussicall corporate for counsel on wheth abuse/neglect. An interview with the CC-RN on 08 been a nurse for over [AGE] years. Resident #1's hand injury and she well and it did not present identical in size on the top and palm said in order to have been burned, and submerge it into a hot liquid. He knew what a burn was and had she unknown origin and proceeded with The CC-RN said that he saw the control of the proceeding that the proceeding that the proceeding that the proceeding that the proceeding the proceeding the proceeding that the proceeding the proceeding the proceeding the proceeding the proceeding that the proceeding that the proceeding the proceedi	B/22 at 2:48 PM revealed she was the elegations to determine if there was abuild initiated investigations and resolved a spend staff or implement things as a resent #1's injury when the DON said she ADON it had something to do with a distate what that disease was and she did day 07/24/22 when the blistering was in the know, If it was an injury of unknow of 22, the DON stat So Monday, the DON said she had just seen the picture were seen that before in my life. They tries to need your clinical expertise. So where a said the DON told her she had seen in up and the body has nowhere to release relied on her, my DON because this waste. I asked during morning meeting to be a said the hospital was inferring that he and she said she would call the hospital and she said she would call the hospital and she said she would call the hospital report it to HHSC as an injury of under the said he trusted the DON's judgement of the hand and the fingers would be someone would of had to take Resider e said that just was not possible and die felt it was a burn, she would have report in investigation. But when she saw it olor photos of Resident #1's left hand a cospital was not open to communications.	ase or not. In the same role, she them one way or another. In that the sult of the allegation. The ADM was sending him out Monday sease, or whatever disease state I not ask. The ADM said no one nitially seen. If it was a burn, the orn origin, absolutely. At the N said Resident #1 had been sent of expectations from his taken by LVN A of Resident #1's ed to show it to me before but I and I saw the picture, when I saw the toefore and there were some see those toxins, they could come as a clinical issue, to let me know it is in on Monday in front of other sease process. So I did not report. Called and talked to MDS RN Fee had been burned. That was when tall and tell them it was not a burn. I was the DON. She said she did not unknown origin and possible The R nurse in the past and had the ent and clinical assessment of a lad she knew what a burn was and I burns, the blisters would not be scalded, which they were not. He at #1's contracted hand, open it up to not happen. He said the DON orted it to ADM as an injury of the did not feel the resident had the with him (specifically the initial).

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/17/2022
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For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informat	ion)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy titled, reflected, The facility will investigat incident report (Gather witness stat ensure completion of documentatic care-planned if required). 2. The inmonitoring as indicated. 4. The DO investigation is complete. 5. Once i QAPI team. On 08/16/22 an Immediate Jeopard remained out of compliance at a se	Investigating Incidents of Unknown Or e incidents of unknown origin .1. The Determination of the Elements, interviewed, follow up on noticident will be tracked on SOC. 3. The Investigation is completed, the document of the Element of the Investigation is completed, the document of the Investigation of	rigin revised January 2020, DON/designee will follow up on the fication of family and physician, new, ensure the incident has been DON/designee will initiated ocumentation daily until the entation should be reviewed by the removed on 08/17/22, the facility ential for more than minimal harm

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/17/2022	
NAME OF PROVIDER OR SUPPLIER Immanuel's Healthcare		STREET ADDRESS, CITY, STATE, ZI 4515 Village Creek Rd Fort Worth, TX 76119	P CODE	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)			
F 0609 Level of Harm - Minimal harm or potential for actual harm	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33552			
Residents Affected - Few	Based on observation, interview, and record review, the facility failed to implement their written policies and procedures that prohibit and prevent abuse, neglect and exploitation of residents and misappropriation of resident's property for one (Resident #1) of five residents reviewed for abuse, neglect, and exploitation.			
	The facility staff failed to report an injury of unknown origin of Resident #1 to HHSC when the resider found to have a significant injury to his left hand, and whose source could not be identified by the fact Resident #1 had to be sent to the ER the following day when he became unresponsive and the blisted tripled in size, where he was diagnosed with second degree burns to his whole left hand, sepsis and urinary tract infection.			
	This failure could place the residen allegations of abuse, neglect, and i	nts at risk for further potential abuse du njuries of unknown origin.	e to unreported and uninvestigated	
	Findings included:			
	Review of facility's Abuse/Neglect policy revised 08/28/17, reflected, .The Abuse Preventionist will be responsible for receiving, leading the appropriate investigation, assure that required reporting is complete timely.			
	Review of Resident #1's quarterly MDS assessment dated [DATE], reflected he was a [AGE] year-old male admitted to the facility originally on 12/08/17 and readmitted on [DATE] from an acute hospital. His active diagnoses included non-Alzheimer's dementia, end-stage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), hypertension (high blood pressure), diabetes, hyperlipidemia (a high level of fat particles in the blood, malnutrition, anxiety disorder, depression, encephalopathy (A broad term for any brain disease that alters brain function or structure) and dysphagia (difficulty swallowing foods or liquids). Resident #1 had unclear speech, was rarely/never understood by others and was rarely/never able to understand others and his vision was highly impaired. He had severely impaired cognitive skills for daily decision making, signs and symptoms of delirium which included inattention and disorganized thinking. Resident #1 had no indicators of psychosis, verbal or physical behaviors or rejection of care. Resident #1's required extensive physical assistance of one or more staff for bed mobility, transfers, dressing, locomotion in his wheelchair, eating, toilet use and personal hygiene and had range of motion impairment in his lower extremities on both sides. Resident #1 was unable to complete a pain interview; the staff pain assessment indicated he did not have any indicators of possible pain during the assessment period.			
	related to immobility and incontiner blisters or discoloration. Intervention breakdown, notifying the nurse imm	(undated) reflected he had the potentiance with a goal of, [Resident #1] will hat one included to follow facility protocols follow facility of any new areas of skin breadare, and obtain and monitor lab/diagnocated.	ve intact skin, free of redness, for the prevention, treatment of skin akdown: redness, blisters, bruises,	

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NAME OF PROVIDER OR SUPPLIER Immanuel's Healthcare		STREET ADDRESS, CITY, STATE, ZI 4515 Village Creek Rd Fort Worth, TX 76119	P CODE
For information on the nursing home's	plan to correct this deficiency, please cont	tact the nursing home or the state survey a	agency.
(X4) ID PREFIX TAG		SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)	
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident dressed this morning, aide blisters, with the biggest one observed over left finger areas. Har and left voicemail for RP. Review of Resident #1's nursing no While doing rounds at the end of sh slightly wet so nurse unwrapped it to noted existing rosy, red area to top drainage however noted to this area filled blisters around existing area, which hand. When nurse asked reside to transfer to ER for further eval and resident's paperwork while resident unresponsive despite being given the Review of SBAR (Situation, Backgram AM reflected Resident #1 had a chafilled blisters to left hand and while pressure at the time of the SBAR was An interview with the hospital criticathe hospital and had been diagnoses aid when she first saw Resident #1 and a large open to the back of his started. His skin on the left hand was and granulated, blistering to all four there were no more skin issues bey happened and he had dementia an inappropriate words. The critical car contracted and immobile. She said her a nursing progress note and dic later and did not believe it was a buand if he had any new oils or lotions of the night on the 24th by an aide, when she told the DON about the band he said no. The critical care RN is not going to do this to himself. The	al care RN on 7/28/22 at 12:37 PM reve ed with second degree burns to his left 1's left hand, she was re-wrapping it to left hand and blistering to the front and as blistered with a giant open area to the digits and thumb on the outside and p rond the left hand. The RN said Reside d previous stokes and baseline of confere RN said the hospital was concerned she called the facility and spoke initiall and not have any further information. The urn. The critical care RN said, I did tell the so, hot water exposure and she told me so that is the note that was read to me ourn, the DON replied that she had ask which said, My thing is he won't even tell you are critical care RN said, He came in sel RN said she felt Resident #1 had an in	f resident's left hand was cluster of a left hand. Other smaller blisters ing and wound care notified. Called M written by LVN A reflected, at, dressing to left hand appeared dressing was taken off, this nurse at open the morning before. No obted multiple huge new clear fluid to large blisters on the left palm of tified immediately and order given intagious issues. While gathering dent noted to become verbally many times. The sident #1 was not listed. Form completed 07/25/22 at 07:30 and had multiple huge fluid the verbally unresponsive. His blood the verbally unresponsive. His blood the back of the hand that was red alm side of the hand. She said and #1 was unable to tell her what the usion with mumbling of because Resident #1 was ywith MDS RN F who only read in the DON called her 30 minutes the DON I thought it was a burn this was first noticed in the middle. This is pretty significant. She said and Resident #1 if he was in pain u his name. He has dementia. He otic, this poor man, I feel bad .it

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NAME OF PROVIDER OR SUPPLIER Immanuel's Healthcare		STREET ADDRESS, CITY, STATE, Z 4515 Village Creek Rd Fort Worth, TX 76119	IP CODE
For information on the purples have le		tact the nursing home or the state survey	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's hospital re 07/25/22 at 8:06 AM and was tachy epithelial skin (the tissue which cox corresponding area on the top part extremities were contracted. The E elevated heart rate, was reported the process. The ED medical doctor's contractions of the atria make the presence of blood in a person's uring unspecified part of lung, and burn, appearing to be a burn but unable. Review of Resident #1's wound/plate to the ED in atrial fibrillation and was threatening medical emergency) where the body, causing an increase in He was unable to provide a history the hand) blisters superior to the pagroup of small bones that comprise fingertip and over middle phalanx (hand with absent epidermis (skin) sincluding tubular bulla of dorsal 1st 1st webspace, several small bullate phalanx. He was noted to be neuroplan by the MD was Wound care to changes liberal bacitracin ointment elevated on pillow. Five photos were consult.	ecords revealed he arrived at the hospity cardic (a heart rate over 100 beats a revers the internal and external surfaces of the hand) of the left hand consistent. D's attending note stated, Patient was that yesterday he sustained some blister final impression/diagnosis was, Atrial fiventricles beat too quickly), urinary tracine), site unspecified, pneumonia of rigit A request was made for wound care to ascertain a source. Institute surgery consult at the hospital data as found to be septic (the body's extrer with a thermal injury (occurs when energy the temperature of local tissue) with be due to his dementia. Resident #1 was almar crease; blisters of [NAME] 5th die the bony core of the digits (fingers) of a bone of the finger); 2) 2nd degree but a be over proximal (situated near) 4th and ological confused and unable follow core to continue management of burn per proximal adaptic/xeroform, ABD pad and loose re taken of Resident #1's left hand by the continue management of a provident was a provident when the continue management of a provident was a pro	tal emergency department on minute) to 170's, blisters and loss of of the body) on the dorsum (the t with possible burns and his upper sent from a nursing home for ers on his hand from an unknown brillation with RVR (when the rapid at infection with hematuria (the nt lung to infectious organism, assess his left hand due to it ed 07/26/22 reflected he presented me response to an infection-life py is transferred from a heat source listers on his left hand and fingers. assessed as, 1) 2 Palmar (palm of git (finger) over phalanges (the the hand), blister on 4th digit irns of the dorsal (top) wrist and in that are filled with clear fluid) blood pools and forms a blister) in 5th digit, bulla of 4th digit middle mmands or provide history. The otocol; recommend daily dressing e Kerlix wrap and to keep hand the hospital at the time of the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	his hand needed to be looked at by RN the day before (07/26/22) who called the hospital RN because of habuse. The DON said she took a prout. She said his left hand was red thought maybe this was cellulitis. So left hand), I told [MD E] it was not pafter being notified on Day 2 of the #1's hand. The DON said when she when Resident #1 was sent out for think. The DON said she did not kn interviewable and sometimes made DON said Resident #1 was not am and wheelchair bound. She said he burn would definitely be red and rawould be white with moisture assoc of the wound and it would be extremely what happened with Resident #1, Indone because it was never anythin care nurse or doctor did not look at is not a burn because those blisters that were not related to burn. That fluid filled and were small and rapic them anything about what happened pain or tearfulness or guardedness. An interview with MDS RN F on 07 out what happened to Resident #1'	/27/22 at 3:15 PM revealed the hospita s hand and said his whole hand was b gress notes to the hospital critical care	ad talked to the critical care hospital burned or abused. The DON then doubt told her it was a skin issue, not anday morning when he was sent led. She said, Initially we had nowed her phone of Resident #1's did not visit Resident #1 in person sicture that she took of Resident doubt gotten on the second day, was felt it was some kind of infection, I let the hospital. She said he was not a pain, but he did not talk at all. The on ADLs and he was bed bound doubt family visitors. The DON said a led it, and around the edges it own fluid leaking out from the edge lee way to 3rd degree. She said DON said an incident report was not bound or injury. She said a wound 24 hours. The DON said, I know it we seen fluid filled blisters like that, his body. She said the blisters were lee said Resident #1 could not tell uli and he never presented with any

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informat	ion)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	07/23/22 and 07/24/22 but did see was clear when she left work on Fr blister on the top of his left hand the was and no one could understand because something real hot would swollen and he had a blister on the normally could talk, but he was not get a reaction, but he was not resp pain. She said by that time, the ove they wanted to do and MD F said to that, she googled burn blisters on t said, But I don't want to say it is a buful that an injury of unknown origin occurred She then said, We don't keep wanted to a month and she was the last in the morning around 11 AM. But I as the MOD, she went to each incidents and accidents and she wallater helped serve dinner. She said aware of Resident #1's hand during already been sent out. MDS RN F.	22 at 10:51 AM revealed she did not see him when she arrived at work on Mondiday 07/22/22 but when she came bact at had already busted and the night nuthow he got blisters like that. LVN B sai have had to caused it. She said Reside pointer finger side going towards the there at all, she shook him, called his onding, which was unusual. She said he programmer (LVN A) had notified the losend him out since no one knew what he hand and the pictures on the interned ourn, because that is not good. LVN B. She said that would be when a person know how this one occurred. Fon 07/28/22 at 11:17 AM revealed see RN manager on duty on Sunday 07/28 She said she had not been notified of a nurses' station, asked how things were as told no. She then went to the MDS of the morning management meeting or said an injury of unknown origin was see, the facility should look into what happy	day 07/25/22. LVN B said his skin k on 07/25/22, he had one big rse (LVN A) was not sure what it d she did not know if it was a burn ent #1's index finger was really thumb. LVN B said Resident #1 name and tried to open his eyes to be could not tell her if he was in DON and physician to see what at had happened. LVN B said after et looked like Resident #1's. LVN B said she did not know if Resident in could not tell how an injury when he had been employed at the 14/22 and had come to the facility any issues related to Resident #1 e going, if there were any new office and did assessments and MDS RN F said she was first made in Monday 07/25/22, after he had omething that was abnormal, that

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility Saturday 2pm-10pm and the overnight shift 10 PM-6 AM. LVN A overnight shift was over Sunday mhis skin and she wanted LVN A to blister right on top of his hand that draining. She said the skin was still dry dressing and put it on the 24 hc LVN A said she did not contact MD Resident #1's left hand injuries bedjust cleaned it and wanted the wou normally work the weekends and the later the oncoming nurse to follow the early morning before the wound that day for her overnight shift (Sur looked at the dressing, it looked lik the amount of new blisters around so the blisters tripled in numbers in cleaned it, wrapped his hand with a as I know, there was nothing that hE and told him about it for the first send Resident #1 to the ER in case don't know if he was reacting to an burn because no one had mentione with the wound wrapped up, I don't know how it occurred. Observation and record review of to 07/23/22 or 07/24/22 related to the An interview with the wound care Leaned anything to her about Remetioned a	se, LVN A, on 07/28/22 at 11:56 AM rese overnight shift (07/23/22) and on Sunta said she was notified by a CNA in the orning (07/25/22) that the CNA was gelook at it. When LVN A went to his roor had popped and little one right next to a nose she did not want to aggressively our report to remind herself. LVN A said a E or an on-call doctor on Sunday 07/2 ause the facility lets the treatment nursing nurse to look at it when she came in nat was why she made a note in the 24 up. However, she said Resident #1 was up. However, she said Resident #1 was did care nurse could look at his hand. When the entire hand, like big, huge blisters was a dry dressing and texted the DON ask and burned him, but the wound was greatime. He said initially he would refer to be he had something contagious since it sything or if he was burned. LVN A said and anything to her, But with the tripling at know. LVN A said an injury of unknown the 24-hour book for Hall 100 (Resident resident. VNN G on 07/28/22 at 07/28/22 at 3:10 did not work over the weekend on 07/2 esident #1's hand and he had already 17/25/22. She said she only found out a stand there could be blistering, discolor be missing due to the degree of the build re-blister, pop on their own and cortical processing and the resident.	day (07/24/22) she worked the early morning hours before the titing him up and noticed issues with m, Resident #1 initially had a big it that had not popped but one was y rub it and she covered it with a d they left him in bed at that time. 24/22 when she first noticed se look at it first. LVN A said she n. She said the wound nurse did not hour report to remind herself and is sent out to the ER the next day in the LVN A came back to work later she was rounding and when she she unwrapped it, there were triple which were not there the day before of his hand. LVN A said she ing her what to do. She said, As far wing. At that point, she called MD a dermatologist, but then said to a came on that rapidly. LVN A said, I she did not initially think it was a of them (the blisters) the next day, an origin was when a person did not the thing had a person did not the came on the hospital by the bout it through hearing people burn could present differently, ation, redness, some swelling due rn. She said most second degree

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	07/22/22 and his skin looked great, Monday morning 07/25/22, she was CNA C said then the overnight nurs of his hand. She said she was work his hands balled up and only moved looking like person who got burned and that he had blisters everywhere because he was blind and only spo C said, I said y'all sure it not a burn what if this is your family member? sternal rub, But nothing, like he was members off the schedule who had investigate, and she just looked at it is looking into it. An interview with CNA D on 07/28/2 time on Resident #1's hall on Satur with him on another hall. She said the was quiet and she was worried I She said he was a typically a heavy on him, he was dry up until 3:50 AN not as much as it used to be could at all her shift until then. When she much and he was laying on his han brown layer of something next to hi hand and saw the entire left layer of up his hand and he groaned when LVN A and asked what happened to being in water too long but he was were huge blisters all over his hand unknowingly, so she told LVN A. Clor move his arms more than to his thimself. She said LVN A wrapped he Resident #1 did seem to be in pain, hand up and started to wipe it dowr like LVN A was not being responsive of her before and pass away, so Resident #1 did seem to be in pain, hand up and started to wipe it dowr like LVN A was not being responsive of her before and pass away, so Resident #1 did seem to be in pain, hand up and started to wipe it dowr like LVN A was not being responsive of her before and pass away, so Resident #1 did seem to be in pain, hand up and started to wipe it dowr like LVN A was not being responsive of her before and pass away, so Resident #1 did seem to be in pain, hand up and started to wipe it dowr like LVN A was not being responsive of her before and pass away, so Resident #1 did seem to be in pain, hand up and started to wipe it dowr like LVN A was not being responsive of her before and pass away, so Resident #1 did seem to be in pain, hand up and started to wipe it dowr	22 at 12:25 PM revealed she had last she could see his hands when she laid is told that he maybe had an infection bee, LVN A took off the dressing and she dering how that could have happened led them to itch his face. CNA C describe, because she had never seen an infection been on his fingers and palm. Resident #1 ke a few words and he was not responsand they were like shhhhh (be quiet so She said when Resident #1 was not responsand they were like shhhhh (be quiet so She said when Resident #1 before that time. She said, If it was my family members and the said, If it was my family members and the told the DO worked with Resident #1 before that time. She said, If it was my family members and the told the polymore was not breathing but then looked by soil and outputs a lot and the entire not and that was unusual. CNA C said in be a sign of the body shutting down. So changed him, it was only urine and it old so she turned him over. When CNA m. She did not know what it was. She if skin on his left hand was missing. She lifted it up and it looked like he had be because it looked fresh because his fing African American. She said Resident #1 was severely inface, he was stuck in the fetal position his hand temporarily because there was a before it was wrapped, he was making and CNA C was panicked because sesident #1's hand made her emotional. So It Itry not to freak out but there was not the fetal position for the polymore. It is hand made her emotional.	I him down. When she saw him ecause his hand was wrapped. I saw he had pink raw skin on top because Resident #1 always kept at Resident #1's left hand as tion that took the skin off like that could not tell her what happened sive, which was not normal. CNA bund) at the same time I was like sponding to her, she tried to do a N that she should take staff me frame just in case, and ter, I would want to know the facility did the overnight shift for the first but she knew him from working, she went in to check on him and loser and saw his chest was rising. Ight when she would go and check continence being not as frequent on the said Resident #1 had not voided could fill her palm so it was not C turned him over, there was a thin bicked it up and then looked at this the said, I was like oh my god, I lifted then burned. CNA C then went to gers where white in color, like 1's hand was soggy and there ed up the piece of his hand skin jured and he could not walk, see, and he could not have burned as puss on his hand. CNA C said aid when she and LVN A pulled his g little groans. CNA D said she felt the had residents get hurt in front She said, Someone that cannot sense of urgency or care. When

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NAME OF PROVIDER OR SUPPLII	ED.	STREET ADDRESS CITY STATE 7	D CODE
	ER	STREET ADDRESS, CITY, STATE, ZI 4515 Village Creek Rd	PCODE
Immanuel's Healthcare		Fort Worth, TX 76119	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informat	ion)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow up interview with the DON Sunday, 07/24/22 around 7AM been his hand and the DON had been not before they erupted. She said he he than his left hand. The DON said sl hand. The DON said an injury of ur from. She said she did not feel Res an injury. She claimed no one from was not supposed to diagnose a re not talk to MD E on Sunday 07/24/2 assumed he had already been calle self-reported incident by the Abuse Resident #1 had the ability to let the extremely painful. The DON said if degree burns, then she would have would be started. An interview with MD E on 07/28/2: attending physician to Resident #1 morning on 07/25/22 and they were Pox going on. He said the facility he for and he did not want it to get loos the facility mentioned it could have on Sunday 07/24/22 for a change in should have notified me for sure. It am not sure if the nurses are sure a sent a photo of Resident #1's hand MD E said he would consider some	on 07/28/22 at 2:26 PM revealed she ause she had to swab him to test for Cotified. When she went to his room, she ad no indicators of pain and there was ne could not remember when she notificated the hospital indicated to her that it was sident, they can describe the situation 22 so she did not describe Resident #1 and Neglect Coordinator because it per know if he was in pain, and he was she had been notified from the hospitate notified the ADM and it would be reported at a side of the side of the facility so he wanted Residen been a burn and no one contacted him condition. MD E said, If a resident has would have needed a description of the facility and they are looking at or seeing. Non 07/25/22 and that was the reason eithing an injury of unknown origin is they and could not identify any infections.	first saw Resident #1's hand on COVID-19. LVN A had already seen a saw the blisters on his left hand no other issues with his skin other ited the ADM about Resident #1's a described as to where it came in, she felt it was an infection, not is a burn. The DON said a nurse to the physician. She said she did 's skin change/injury to him, I alify to be called to HHSC as a resented as an infection and in not, and a burn would be all that the resident had second orted to HHSC and an investigation itical director for the facility and ing contacted by the facility Monday which was a bug deal with Monkey number one on his list to watch out the #1 sent out. He said no one from the when the injury was first identified is big blisters all over his hand, they be lesions. He said, A lot of times, I MD E said he remembered being the sent him out, when he saw it.

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			No. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/17/2022
NAME OF PROVIDER OR SUPPLII	NAME OF PROVIDER OR SUPPLIER Immanuel's Healthcare		P CODE
		Fort Worth, TX 76119	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	ion)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	coordinator and she investigated a reported any suspicious injuries an process, the ADM said she may sus aid she was first told about Reside morning on 07/25/22. She told the he was in, but the ADM could not so notified her about the injury on Sur ADM said the DON should have less tand-up meeting on Monday 07/25 out already and that he had some diagnosis of whatever that is. The left hand. The ADM said, I have ne have a weak stomach. I will say I jublisters, I was like what is that? She diseases that when there is a flare out like that. The ADM stated, So I this was a reportable incident to St about whether it was reportable an ADM further said after the admission MDS RN F came to her and said the ADM said she went to the DON an ADM said she did not discuss Resicorporate for counsel on whether to abuse/neglect. An interview with the CC-RN on 08 been a nurse for over [AGE] years. Resident #1's hand injury and she he did as well and it did not presen identical in size on the top and palr said in order to have been burned, and submerge it into a hot liquid. Hence what a burn was and had she unknown origin and proceeded witl The CC-RN said that he saw the coat the termal burn injury. He said the MD evaluator of the burn) and he he MD evaluator of the burn) and he here.	8/22 at 2:48 PM revealed she was the llegations to determine if there was abd d initiated investigations and resolved ispend staff or implement things as a rent #1's injury when the DON said she ADON it had something to do with a distate what that disease was and she did adoy 07/24/22 when the blistering was it her know, If it was an injury of unknow 5/22, the DON stat So Monday, the DO olisters and they were not out of the not ADM said she had just seen the picture wer seen that before in my life. They triust need your clinical expertise. So where said the DON told her she had seen if up and the body has nowhere to release relied on her, my DON because this was ate. I asked during morning meeting to dishe said no, it was part of his disease on to the hospital, a hospital nurse called the hospital was inferring that he had be done the said she would call the hospital was dent #1's injury with anyone else, just the proportion of the hospital was a thermal burn. He see the said he trusted the DON's judgement of the hand and the fingers would be someone would of had to take Reside the said that just was not possible and die felt it was a burn, she would have reported to the hours trying to contact them is an investigation. But when she saw it color photos of Resident #1's left hand an ospital was not open to communicating and spent hours trying to contact them is an investigation. But when she saw it color photos of Resident #1's left hand an ospital was not open to communicating and spent hours trying to contact them is an investigation to the facility for admissional spent hours trying to contact them is an investigation to the facility for admissional spent hours trying to contact them is the discount of the hours trying to contact them is the properties of the facility when he was discharged.	them one way or another. In that them one way or another. In that them one way or another. In that the sult of the allegation. The ADM was sending him out Monday sease, or whatever disease state of not ask. The ADM said no one initially seen. If it was a burn, the win origin, absolutely. At the the them is a taken by LVN A of Resident #1's are to show it to me before but I are I saw the picture, when I saw the it before and there were some as a clinical issue, to let me know if on Monday in front of other staff are process. So I did not report. The ead and talked to MDS RN F and the ten burned. That was when the eard tell them it was not a burn. The the DON. She said she did not call nown origin and possible In ER nurse in the past and had ent and clinical assessment of aid she knew what a burn was and all burns, the blisters would not be scalded, which they were not. He int #1's contracted hand, open it up, ind not happen. He said the DON to the did not feel the resident had gwith him (specifically the initial to discuss the injury. The CC-RN

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/17/2022
NAME OF PROVIDER OR SUPPLIER Immanuel's Healthcare		STREET ADDRESS, CITY, STATE, ZI 4515 Village Creek Rd Fort Worth, TX 76119	IP CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informat	ion)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reporting Guidelines to Home Office sutures, 2. All hospitalization s from resident's injury. Notify the physicial facts and environmental factors surrequired. Document notification of Reporting Guidelines to the State of contact Director of Risk manageme Office, [NAME] Texas within 24 how has cause to believe that the physical adversely affected by the abuse or Report all injuries that are determine	Reporting Incidents; State and Home ce: .1. All fractures, serious head injuring an injury or unusual occurrence; .17. In and family member or legal guardian rounding the variance. Document vital all applicable parties in the clinical reconf Texas: f there is a question about when the for clarification. All incidents must burs of learning of the incident; .Report: cal or mental health or welfare or a resenglect .5. Abuse Allegation .6. Neglewed to be serious by the examining physt. Report the serious injury ONLY of it ances within the facility.	es, burns, lacerations requiring Complete an incident report of the n for all injury reports. Document all signs and assessment results as ord and on Incident Report. nat to report or what not to report, ne reported to the DADS State 1. Any facility or staff member who sident has been or may be ct Allegations .7. Serious Injury: resician or designee, nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 676052 NAME OF PROVIDER OR SUPPLIES Immanuel's Healthcare STREET ADDRESS, CITY, STATE, ZIP CODE 4515 Village Cnex Rd For Worth, TX 76119 For information on the nursing homes's plan to correct this deficiency, please contact the nursing homes or the state survey agency. While D PREFIX TAC SUMMARY STATEMENT OF DEFICIENCIES (Size) deficiency must be preceded by full regulatory or LSC identifying information) Respond appropriately to all alleged violations. "NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY" 33552 Based on observation, intensive, and record review, the facility failed to have evidence that all alleged violations. "NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY" 33552 Based on observation, intensive, and record review, the facility failed to thave evidence that all alleged violations are subject to the protect of turber potential abuse, neglect, exploitation or mistreament while the investigation is progress for one (Resident #1) of the resident feet was found to have a significant injury to his left hand, whose source could not be identified by the facility. Resident #1 the facility and whose source could not be identified by the facility. Resident #1 the facility and whose source could not be identified by the facility. Resident infection. The health or subject is an injury of unknown origin of Resident #1 than, sepsia and a unimous track infection. The health of the Text the facility of the resident was found to have a significant injury to his left hand, on the bear the unimous track in the facility of the resident and the resident hand, sepsia and a unimous track in the facility of the resident and the resident hand, sepsia and a unimous track in the facility of the resident					
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(continued on next page)		responsible for receiving, leading the			
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NAME OF PROVIDER OR SUPPLIER Immanuel's Healthcare		STREET ADDRESS, CITY, STATE, ZI 4515 Village Creek Rd Fort Worth, TX 76119	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	ion)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	admitted to the facility originally on diagnoses included non-Alzheimer person's kidneys cease functioning long-term dialysis or a kidney trans hyperlipidemia (a high level of fat pencephalopathy (A broad term for a (difficulty swallowing foods or liquic others and was rarely/never able to impaired cognitive skills for daily de and disorganized thinking. Resider rejection of care. Resident #1's req transfers, dressing, locomotion in hmotion impairment in his lower extrinterview; the staff pain assessment assessment period. Review of Resident #1's care plan related to immobility and incontiner blisters or discoloration. Interventio breakdown, notifying the nurse immidiscoloration noted during bath or cresults to MD and follow up as indicated to the second over left finger areas. Ha and left voicemail for RP. Review of Resident #1's nursing noted existing rounds at the end of slightly wet so nurse unwrapped it noted existing rosy, red area to top drainage however noted to this are filled blisters around existing area, his hand. When nurse asked reside to transfer to ER for further eval an resident's paperwork while residen unresponsive despite being given to	MDS assessment dated [DATE], reflect 12/08/17 and readmitted on [DATE] for some depending on a permanent basis leading to the number of the plant to maintain life), hypertension (high articles in the blood, malnutrition, anxieties and bis vision was ecision making, signs and symptoms of the	om an acute hospital. His active a medical condition in which a need for a regular course of gh blood pressure), diabetes, ety disorder, depression, tion or structure) and dysphagia was rarely/never understood by highly impaired. He had severely f delirium which included inattention erbal or physical behaviors or one or more staff for bed mobility, ersonal hygiene and had range of sunable to complete a pain ors of possible pain during the all for alteration in skin integrity ove intact skin, free of redness, for the prevention, treatment of skin akdown: redness, blisters, bruises, ostic work as ordered. Report 252 AM reflected, While getting of resident's left hand was cluster of its left hand. Other smaller blisters sing and wound care notified. Called the written by LVN A reflected, and, dressing to left hand appeared dressing was taken off, this nurse st open the morning before. No noted multiple huge new clear fluid to large blisters on the left palm of otified immediately and order given intagious issues. While gathering ident noted to become verbally many times.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety	Review of SBAR (Situation, Background, Assessment, Recommendation) Form completed 07/25/22 at 07:30 AM reflected Resident #1 had a change in condition that started on 07/24/22 and had multiple huge fluid filled blisters to left hand and while awaiting transport to the ER, he became verbally unresponsive. His blood pressure at the time of the SBAR was 94/53 and his pulse was 75.		
Residents Affected - Few	AM reflected Resident #1 had a change in condition that started on 07/24/22 and had multiple huge filled blisters to left hand and while awaiting transport to the ER, he became verbally unresponsive.		hand, sepsis and a UTI. The RN do wound care. He had blistering it back down to where the wrist he back of the hand that was red halm side of the hand. She said ent #1 was unable to tell her what fusion with mumbling of I because Resident #1 was y with MDS RN F who only read in the DON called her 30 minutes the DON I thought it was a burn this was first noticed in the middle of this was first noticed in the middle of this is pretty significant. She said and Resident #1 if he was in pain but his name. He has dementia. He pitic, this poor man, I feel bad .it highly of unknown origin and it was tall emergency department on aninute) to 170's, blisters and loss of the body) on the dorsum (the to with possible burns and his upper sent from a nursing home for rs on his hand from an unknown orillation with RVR (when the rapid tinfection with hematuria (the int lung to infectious organism,

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	to the ED in atrial fibrillation and was threatening medical emergency) we to the body, causing an increase in He was unable to provide a history the hand) blisters superior to the particle of the particle	astic surgery consult at the hospital date as found to be septic (the body's extremith a thermal injury (occurs when energy the temperature of local tissue) with be due to his dementia. Resident #1 was almar crease; blisters of [NAME] 5th dige the bony core of the digits (fingers) of a bone of the finger); 2) 2nd degree buseveral bullae (large blisters on the sking webspace, hemorrhagic blister (when a over proximal (situated near) 4th and ological confused and unable follow core occurrence of continue management of burn per proximal adaptic/xeroform, ABD pad and loose are taken of Resident #1's left hand by the taken of the taken of a providery of unknown origin.	ne response to an infection-life by is transferred from a heat source listers on his left hand and fingers. assessed as, 1) 2 Palmar (palm of git (finger) over phalanges (the the hand), blister on 4th digit rns of the dorsal (top) wrist and in that are filled with clear fluid) blood pools and forms a blister) in 5th digit, bulla of 4th digit middle inmands or provide history. The btocol; recommend daily dressing a Kerlix wrap and to keep hand the hospital at the time of the

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NAME OF PROVIDER OR SUPPLIE	In .	STREET ADDRESS CITY STATE 71	D CODE
	EK .	STREET ADDRESS, CITY, STATE, ZI 4515 Village Creek Rd	PCODE
Immanuel's Healthcare		Fort Worth, TX 76119	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with the DON on 07/2' his hand needed to be looked at by RN the day before (07/26/22) who called the hospital RN because of habuse. The DON said she took a pi out. She said his left hand was red thought maybe this was cellulitis. S left hand), I told [MD E] it was not pafter being notified on Day 2 of the #1's hand. The DON said when she when Resident #1 was sent out for think. The DON said she did not kn interviewable and sometimes made DON said Resident #1 was not am and wheelchair bound. She said he burn would definitely be red and rawould be white with moisture assoc of the wound and it would be extre what happened with Resident #1, I done because it was never anythin care nurse or doctor did not look at is not a burn because those blisters that were not related to burn. That I fluid filled and were small and rapic them anything about what happene pain or tearfulness or guardedness. An interview with MDS RN F on 07 out what happened to Resident #1'	7/22 at 3:00 PM revealed Resident #1 or a higher level. She said MDS RN F has had implied that Resident #1 had been her feeling the resident was abused and icture of Resident #1's left hand on Mowith a cluster of blisters that had erupt he then said, When I saw it like this (shoresenting as cellulitis. She said MD E or blisters and she did not send him the property of the blisters and she did not send him the property of the blisters had further evaluation. The DON said she was worked whow Resident #1 was doing while a prunts or would moan when he was in bulatory, was almost max dependence the never went out on pass and rarely had with the property active the painful and in various stages all the property painful and in various stages all the property active with and the blisters all happened within a did not present like it was a burn. I had looked like a fluid infection going on in ally grew over the course of that day. She do but he could respond to painful stimular property of the course of that day. She hand and said his whole hand was be gress notes to the hospital critical care.	was sent to the hospital because ad talked to the critical care hospital burned or abused. The DON then do told her it was a skin issue, not anday morning when he was sent ed. She said, Initially we had nowed her phone of Resident #1's did not visit Resident #1 in person picture that she took of Resident dogotten on the second day, was felt it was some kind of infection, I at the hospital. She said he was not a pain, but he did not talk at all. The on ADLs and he was bed bound dof family visitors. The DON said a sind it, and around the edges it own fluid leaking out from the edge he way to 3rd degree. She said DON said an incident report was not ound or injury. She said a wound 24 hours. The DON said, I know it we seen fluid filled blisters like that, his body. She said the blisters were he said Resident #1 could not tell uli and he never presented with any

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/17/2022
NAME OF PROVIDER OR SUPPLIER Immanuel's Healthcare		STREET ADDRESS, CITY, STATE, ZI 4515 Village Creek Rd Fort Worth, TX 76119	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	07/23/22 and 07/24/22 but did see was clear when she left work on Fr blister on the top of his left hand th was and no one could understand because something real hot would swollen and he had a blister on the normally could talk, but he was not get a reaction, but he was not resp pain. She said by that time, the ove they wanted to do and MD F said to that, she googled burn blisters on the said, But I don't want to say it is a buful that an injury of unknown origin occurred She then said, We don't want to say it is a buful to the waste occurred. A follow up interview with MDS RN facility for a month and she was the last in the morning around 11 AM. but as the MOD, she went to each incidents and accidents and she waste of Resident #1's hand during already been sent out. MDS RN F.	22 at 10:51 AM revealed she did not se him when she arrived at work on Monoriday 07/22/22 but when she came back at had already busted and the night nu how he got blisters like that. LVN B sai have had to caused it. She said Reside pointer finger side going towards the tother at all, she shook him, called his conding, which was unusual. She said hernight nurse (LVN A) had notified the for send him out since no one knew what he hand and the pictures on the interned ourn, because that is not good. LVN B so she said that would be when a person know how this one occurred. For 07/28/22 at 11:17 AM revealed so the RN manager on duty on Sunday 07/28 She said she had not been notified of a nurses' station, asked how things were as told no. She then went to the MDS of the morning management meeting or said an injury of unknown origin was so, the facility should look into what happens of the province of the facility should look into what happens of the facility shappens of the facility should look into the facility should look	lay 07/25/22. LVN B said his skin on 07/25/22, he had one big ree (LVN A) was not sure what it d she did not know if it was a burn ent #1's index finger was really humb. LVN B said Resident #1 name and tried to open his eyes to be could not tell her if he was in DON and physician to see what thad happened. LVN B said after et looked like Resident #1's. LVN B said she did not know if Resident in could not tell how an injury when he had been employed at the 4/22 and had come to the facility any issues related to Resident #1 going, if there were any new office and did assessments and IDS RN F said she was first made a Monday 07/25/22, after he had benething that was abnormal, that

CTATEMENT OF BEFORENCES	(VI) DDO//IDED/CURRY IER/CUR	(V2) MULTIPLE CONSTRUCTION	(VZ) DATE CUDYEV
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676052	A. Building B. Wing	08/17/2022
NAME OF PROVIDER OR SUPPLI	⊥ ER	STREET ADDRESS, CITY, STATE, ZI	P CODE
Immanuel's Healthcare		4515 Village Creek Rd Fort Worth, TX 76119	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	facility Saturday 2pm-10pm and the overnight shift 10 PM-6 AM. LVN A overnight shift was over Sunday me his skin and she wanted LVN A to blister right on top of his hand that draining. She said the skin was still dry dressing and put it on the 24 he LVN A said she did not contact MD Resident #1's left hand injuries bed just cleaned it and wanted the wou normally work the weekends and the learly morning before the wound that day for her overnight shift (Sur looked at the dressing, it looked like the amount of new blisters around so the blisters tripled in numbers in cleaned it, wrapped his hand with a as I know, there was nothing that he and told him about it for the first it send Resident #1 to the ER in case don't know if he was reacting to any burn because no one had mentione with the wound wrapped up, I don't know how it occurred. Observation and record review of the O7/23/22 or O7/24/22 related to the mentioned anything to her about R time she arrived at work Monday Of talking about it conversationally in the degree, and some skin may	see, LVN A, on 07/28/22 at 11:56 AM rese overnight shift (07/23/22) and on Suntasaid she was notified by a CNA in the prining (07/25/22) that the CNA was geook at it. When LVN A went to his roor had popped and little one right next to lon so she did not want to aggressively our report to remind herself. LVN A said a E or an on-call doctor on Sunday 07/2 ause the facility lets the treatment nursing nurse to look at it when she came in nat was why she made a note in the 24 up. However, she said Resident #1 was docare nurse could look at his hand. When the entire hand, like big, huge blisters was at dry dressing and texted the DON asking and burned him, but the wound was grown and the said initially he would refer to be he had something contagious since it ything or if he was burned. LVN A said and anything to her, But with the tripling know. LVN A said an injury of unknown the 24-hour book for Hall 100 (Resident resident. VN G on 07/28/22 at 07/28/22 at 3:10 did not work over the weekend on 07/2 esident #1's hand and he had already of the facility. Wound Care LVN G said a said there could be blistering, discolor be missing due to the degree of the build re-blister, pop on their own and cor	day (07/24/22) she worked the early morning hours before the ting him up and noticed issues with in, Resident #1 initially had a big it that had not popped but one was it that had not hour lead to have a selected and selected had a selected

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/17/2022
NAME OF PROVIDER OR SUPPLIE	ER	STREET ADDRESS, CITY, STATE, ZI	P CODE
Immanuel's Healthcare		4515 Village Creek Rd Fort Worth, TX 76119	
For information on the nursing home's	plan to correct this deficiency, please conf	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	EIENCIES full regulatory or LSC identifying informati	on)
Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	07/22/22 and his skin looked great, Monday morning 07/25/22, she was CNA C said then the overnight nurs of his hand. She said she was work his hands balled up and only movel looking like person who got burned and that he had blisters everywhere because he was blind and only spo C said, I said y'all sure it not a burn what if this is your family member? sternal rub, But nothing, like he was members off the schedule who had investigate, and she just looked at a is looking into it. An interview with CNA D on 07/28/2 time on Resident #1's hall on Satur with him on another hall. She said he was quiet and she was worried I She said he was a typically a heavy on him, he was dry up until 3:50 AN not as much as it used to be could at all her shift until then. When she much and he was laying on his hand brown layer of something next to hi hand and saw the entire left layer of up his hand and he groaned when being in water too long but he was were huge blisters all over his hand unknowingly, so she told LVN A. Clor move his arms more than to his himself. She said LVN A wrapped he Resident #1 did seem to be in pain, hand up and started to wipe it down like LVN A was not being responsive of her before and pass away, so Remove, cannot do this to themselves she (LVN A) wrapped his hand too, was like, just dry gauze on the open her the rest of the shift and CNA D	22 at 12:25 PM revealed she had last she could see his hands when she laid is told that he maybe had an infection bee, LVN A took off the dressing and she dering how that could have happened lid them to itch his face. CNA C describe, because she had never seen an infection on his fingers and palm. Resident #1 ke a few words and he was not responding the year like shhhhh (be quiet so She said when Resident #1 was not responding it. CNA C said she told the DO worked with Resident #1 before that time. She said, If it was my family member and the year like a few words and he was not be a sign of the body shutting down. She as a sign of the body shutting down. She had not know what it was. She if skin on his left hand was missing. She lifted it up and it looked like he had be because it looked fresh because his find African American. She said Resident #1 was severely in face, he was stuck in the fetal position his hand temporarily because there was not before it was wrapped, he was making the and CNA C was panicked because she before it was wrapped, he was making the and CNA C was panicked because she before it was wrapped, he was making the and the control of the pool of the body about her control of the pool of th	d him down. When she saw him ecause his hand was wrapped. It is saw he had pink raw skin on top because Resident #1 always kept and Resident #1's left hand as stion that took the skin off like that could not tell her what happened sive, which was not normal. CNA bound) at the same time I was like asponding to her, she tried to do a N that she should take staff me frame just in case, and her, I would want to know the facility do the overnight shift for the first but she knew him from working, she went in to check on him and loser and saw his chest was rising. Ight when she would go and check continence being not as frequent or he said Resident #1 had not voided would fill her palm so it was not C turned him over, there was a thin picked it up and then looked at this e said, I was like oh my god, I lifted the burned. CNA C then went to gers where white in color, like 1's hand was soggy and there ed up the piece of his hand skin jured and he could not walk, see, and he could not have burned as puss on his hand. CNA C said aid when she and LVN A pulled his glittle groans. CNA D said she felt she had residents get hurt in front She said, Someone that cannot sense of urgency or care. When pad and wrapped it real quick. I CNA D said LVN A did not talk to terns and not wanting to work with

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NAME OF PROMERT OF CURRIEF		CTREET ADDRESS CITY STATE 7	D. CODE
NAME OF PROVIDER OR SUPPLI	ER	STREET ADDRESS, CITY, STATE, ZI 4515 Village Creek Rd	PCODE
Immanuel's Healthcare		Fort Worth, TX 76119	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		ion)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Sunday, 07/24/22 around 7AM bed his hand and the DON had been not before they erupted. She said he his hand. The DON said shand. The DON said an injury of ur from. She said she did not feel Resident an injury. She claimed no one from was not supposed to diagnose a renot talk to MD E on Sunday 07/24/2 assumed he had already been called self-reported incident by the Abuse Resident #1 had the ability to let the extremely painful. The DON said if degree burns, then she would have would be started. An interview with MD E on 07/28/2 attending physician to Resident #1 morning on 07/25/22 and they were Pox going on. He said the facility her for and he did not want it to get loo the facility mentioned it could have on Sunday 07/24/22 for a change is should have notified me for sure. I am not sure if the nurses are sure a sent a photo of Resident #1's hand MD E said she would consider som	on 07/28/22 at 2:26 PM revealed she ause she had to swab him to test for Cotified. When she went to his room, she ad no indicators of pain and there was he could not remember when she notification origin was one that could not be ident #1 had an injury of unknown origin the hospital indicated to her that it was esident, they can describe Resident #1 and Neglect Coordinator because it prem know if he was in pain, and he was she had been notified from the hospitate notified the ADM and it would be reported to asking him about the lesions he had ad no cases of Monkey Pox but it was see in the facility so he wanted Residen been a burn and no one contacted him in condition. MD E said, If a resident had would have needed a description of the forwhat they are looking at or seeing. Non 07/25/22 and that was the reason her had an injury of unknown origin is the ty and could not identify any infections.	covID-19. LVN A had already seen as saw the blisters on his left hand no other issues with his skin other ited the ADM about Resident #1's to described as to where it came in, she felt it was an infection, not is a burn. The DON said a nurse to the physician. She said she did 's skin change/injury to him, I alify to be called to HHSC as a resented as an infection and is not, and a burn would be all that the resident had second orted to HHSC and an investigation itical director for the facility and ing contacted by the facility Monday which was a bug deal with Monkey number one on his list to watch out the transition of the injury was first identified its big blisters all over his hand, they be lesions. He said, A lot of times, I MD E said he remembered being the sent him out, when he saw it the facility did not have any

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/17/2022	
NAME OF PROVIDER OR SUPPLII	FR	STREET ADDRESS, CITY, STATE, ZI	P CODE	
Immanuel's Healthcare		4515 Village Creek Rd		
		Fort Worth, TX 76119		
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		ion)	
F 0610	An interview with the ADM on 07/2	8/22 at 2:48 PM revealed she was the	facility abuse and neglect	
	coordinator and she investigated al	llegations to determine if there was abu	use or not. In the same role, she	
Level of Harm - Immediate jeopardy to resident health or		d initiated investigations and resolved spend staff or implement things as a re		
safety	1	ent #1's injury when the DON said she	- C	
5	, ,	ADON it had something to do with a di		
Residents Affected - Few		state what that disease was and she did aday 07/24/22 when the blistering was i		
	, , ,	t her know, If it was an injury of unknow	•	
	, ,	5/22, the DON stat So Monday, the DO		
	1	olisters and they were not out of the no	•	
	diagnosis of whatever that is. The ADM said she had just seen the picture taken by LVN A of Resident #1's left hand. The ADM said, I have never seen that before in my life. They tried to show it to me before but I			
		ust need your clinical expertise. So whe		
		e said the DON told her she had seen in up and the body has nowhere to releas		
		relied on her, my DON because this w		
	this was a reportable incident to Sta	ate. I asked during morning meeting to	o in on Monday in front of other	
		le and she said no, it was part of his dinission to the hospital, a hospital nurse		
		d said the hospital was inferring that he		
		I and she said she would call the hospi		
		Resident #1's injury with anyone else, er to report it to HHSC as an injury of it		
	abuse/neglect.	, , , , , , , , , , , , , , , , , , ,	.	
	An interview with the CC-RN on 08	:/15/22 at 11:15 AM revealed he was a	n FR nurse in the past and had	
		He said he trusted the DON's judgement	•	
		did not feel it was a thermal burn. He s		
		t as such. CC-RN stated with a therma n of the hand and the fingers would be		
	identical in size on the top and palm of the hand and the fingers would be scalded, which they were not. He said in order to have been burned, someone would of had to take Resident #1's contracted hand, open it up,			
	and submerge it into a hot liquid. He said that just was not possible and did not happen. He said the DON knew what a burn was and had she felt it was a burn, she would have reported it to ADM as an injury of			
		e felt it was a burn, she would have rep n an investigation. But when she saw it		
	,	olor photos of Resident #1's left hand a		
	a thermal burn injury. He said the h	nospital was not open to communicating	g with him (specifically the initial	
		and spent hours trying to contact them to end residents to the facility for admissi		
	Resident #1 to come back to the fa		on and the plan fornalised for	
	(continued on next page)			
	(continued on next page)			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/17/2022
NAME OF PROVIDER OR SUPPLIER Immanuel's Healthcare		STREET ADDRESS, CITY, STATE, Z 4515 Village Creek Rd Fort Worth, TX 76119	IP CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		ion)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy titled, reflected, The facility will investigat incident report (Gather witness statensure completion of documentatic care-planned if required). 2. The inmonitoring as indicated. 4. The DO investigation is complete. 5. Once QAPI team. On 08/16/22 an Immediate Jeopard	Investigating Incidents of Unknown Or e incidents of unknown origin .1. The Interest interviewed, follow up on notice incomplete the quality assurance revisited in the sum of the designed should follow up on the designed should follow up on the designed investigation is completed, the documental of the sum	rigin revised January 2020, DON/designee will follow up on the fication of family and physician, lew, ensure the incident has been DON/designee will initiated cumentation daily until the entation should be reviewed by the removed on 08/17/22, the facility

			No. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/17/2022
NAME OF PROVIDER OR SUPPLIER Immanuel's Healthcare		STREET ADDRESS, CITY, STATE, ZI 4515 Village Creek Rd Fort Worth, TX 76119	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	ltact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		ion)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS IN Based on observation, interview ar with professional standards of pract of five residents reviewed for quality. The facility failed to ensure Reside condition in his skin when the reside hand. He was given a treatment for Resident #1 had to be sent to the Etripled in size, where he was diagnurinary tract infection. This failure placed residents at risk of life, serious illness and hospitalized on 08/16/22 an Immediate Jeopard remained out of compliance at a set is not Immediate Jeopardy with a simplementation and effectiveness on 08/16/22 at 2:21 PM. Findings included: Review of Resident #1's quarterly ladmitted to the facility originally on diagnoses included non-Alzheimer person's kidneys cease functioning long-term dialysis or a kidney transhyperlipidemia (a high level of fat pencephalopathy (A broad term for a (difficulty swallowing foods or liquic others and was rarely/never able to impaired cognitive skills for daily de and disorganized thinking. Resider rejection of care. Resident #1's requand transfers, dressing, locomotion in motion impairment in his lower extransfers, dressing, locomotion in the motion impairment in his lower extransfers.	nt #1 was accurately assessed, monitor lent was found to have a significant injur wound care without the physician being ER the following day when he became osed with second degree burns to his was for skin alteration and injuries and countries.	ceatment and care in accordance ered care plan for one (Resident #1) ared, and treated for an change of any of unknown source to his left any notified or providing orders. aurresponsive and the blisters had whole left hand, sepsis and a and for more than minimal harm that inuing to monitor the ministrator received the IJ template and acute hospital. His active a medical condition in which a leed for a regular course of gh blood pressure), diabetes, ety disorder, depression, tion or structure) and dysphagia was rarely/never understood by highly impaired. He had severely felirium which included inattention or broad or physical behaviors or one or more staff for bed mobility, arsonal hygiene and had range of sunable to complete a pain

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/17/2022
NAME OF PROVIDER OR SUPPLIER Immanuel's Healthcare		STREET ADDRESS, CITY, STATE, ZI 4515 Village Creek Rd Fort Worth, TX 76119	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's care plander related to immobility and incontiner blisters or discoloration. Intervention breakdown, notifying the nurse immobilisters or discoloration noted during bath or or results to MD and follow up as indiced as a second of the plant o	(undated) reflected he had the potential rice with a goal of, [Resident #1] will han sincluded to follow facility protocols finediately of any new areas of skin breakare, and obtain and monitor lab/diagnocated. In the weekly skin assessment completed sing, skin tears, abrasions, lacerations, s. In this site identification from and shows washed and nails were cleaned with the weekly skin assessment completed sing, skin tears, abrasions, lacerations, s. In this site identification from and shows washed and nails were cleaned with the weekly skin issues. On top of the weekly skin issues. On top of the weekly skin issues. On top of weekly skin issues. On top of weekly standard with the weekly skin issues. On top of weekly standard with the weekly skin issues. On top of weekly standard with the was in pain, he said no .MD not at was seated at the nurses' station, resident to the weekly standard was being shaken in accident logs for July 2022 revealed Fround, Assessment, Recommendation) ange in condition that started on 07/24, awaiting transport to the ER, he became	If for alteration in skin integrity we intact skin, free of redness, or the prevention, treatment of skin kdown: redness, blisters, bruises, ostic work as ordered. Report by LVN A on 07/21/22 reflected his surgical incisions, rash, moisture ver sheet dated 07/22/22 reflected no indication of skin alteration. 52 AM reflected, While getting fresident's left hand was cluster of s left hand. Other smaller blisters ing and wound care notified. Called der for treatment to his left hand. M written by LVN A reflected, nt, dressing to left hand appeared dressing was taken off, this nurse at open the morning before. No oted multiple huge new clear fluid or large blisters on the left palm of tiffied immediately and order given intagious issues. While gathering dent noted to become verbally many times. Resident #1 was not listed. Form completed 07/25/22 at 07:30 (22 and had multiple huge fluid

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN OF CORRECTION		A. Building	
	676052	B. Wing	08/17/2022
NAME OF PROVIDER OR SUPPLI	NAME OF PROVIDER OR SUPPLIER		P CODE
Immanuel's Healthcare		4515 Village Creek Rd	
		Fort Worth, TX 76119	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the hospital and had been diagnoss said when she first saw Resident # and a large open to the back of his started. His skin on the left hand wand granulated, blistering to all four there were no more skin issues bey happened and he had dementia an inappropriate words. The critical care contracted and immobile. She said her a nursing progress note and did later and did not believe it was a bud ressing which was not appropriate applied to a burn such as Resident removed. The critical care RN said responded they had notified the wows a burn and if he had any new the middle of the night on the 24th significant. She said when she told #1 if he was in pain and he said no He has dementia. He is not going to man, I feel bad the made me so made origin and it was suspicious because. Review of Resident #1's hospital reconfigured to the part extremities were contracted. The E elevated heart rate, was reported the process. The ED medical doctor's for contractions of the atria make the was presence of blood in a person's uring the said was understant and the presence of blood in a person's uring the said was tached to the said of the atria make the was presence of blood in a person's uring the said was tached to the said of the atria make the was presence of blood in a person's uring the said was tached to the said of the said was tached to the said of the said was tached to the said was tach	al care RN on -7/28/22 at 12:37 PM reveled with second degree burns to his left 1's left hand, she was re-wrapping it to left hand and blistering to the front and as blistered with a giant open area to the digits and thumb on the outside and plyond the left hand. The RN said Reside of previous stokes and baseline of confirmer RN said the hospital was concerned she called the facility and spoke initially digital to thave any further information. The urn. The critical care RN said, Anyone of any it is should have been a wet dressing. It is should stick to the was the DON about the burn, the DON rep. The critical care RN said, My thing is to do this to himself. The critical care RN said she felt Resist it was not an injury that he could do be cords revealed he arrived at the hospit cardic (a heart rate over 100 beats a refers the internal and external surfaces of the hand) of the left hand consisten. D's attending note stated, Patient was not a yesterday he sustained some blister in all impression/diagnosis was, Atrial fill rentricles beat too quickly), urinary tracine), site unspecified, pneumonia of right A request was made for wound care to to ascertain a source.	hand, sepsis and a UTI. The RN do wound care. He had blistering if back down to where the wrist he back of the hand that was red halm side of the hand. She said ent #1 was unable to tell her what fusion with mumbling of a because Resident #1 was y with MDS RN F who only read in the DON called her 30 minutes can tell it is a burn. They did a dry She said if a dry dressing was ound and worsen it when it was nat dressing and the DON aid, I did tell the DON I thought it is told me this was first noticed in read to me .This is pretty lied that she had asked Resident he won't even tell you his name. In said, He came in septic, this poor sident #1 had an injury of unknown to himself. It all emergency department on ininute) to 170's, blisters and loss of of the body) on the dorsum (the tail with possible burns and his upper sent from a nursing home for rs on his hand from an unknown brillation with RVR (when the rapid tinfection with hematuria (the int lung to infectious organism,

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/17/2022
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE
Immanuel's Healthcare		4515 Village Creek Rd Fort Worth, TX 76119	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	to the ED in atrial fibrillation and was threatening medical emergency) wis to the body, causing an increase in He was unable to provide a history the hand) blisters superior to the pagroup of small bones that comprise fingertip and over middle phalanx (hand with absent epidermis (skin) sincluding tubular bulla of dorsal 1st 1st webspace, several small bullae phalanx. He was noted to be neuro plan by the MD was Wound care to changes liberal bacitracin ointment elevated on pillow. Five photos were consult. An interview with the DON on 07/2' his hand needed to be looked at by RN the day before (07/26/22) who called the hospital RN because of habuse. The DON said she took a piout. She said his left hand was red thought maybe this was cellulitis. S left hand), I told [MD E] it was not pafter being notified on Day 2 of the #1's hand. She did not have a reas when she saw how much bigger thout for further evaluation. The DON not know how Resident #1 was doi sometimes made grunts or would in Resident #1 was not ambulatory, wheelchair bound. She said he new would definitely be red and raw, it is white with moisture associated skir wound and it would be extremely phappened with Resident #1, happe because it was never anything to wourse or doctor did not look at it an a burn because those blisters did in were not related to burn. That looke fluid filled and were small and rapic them anything about what happened pain or tearfulness or guardedness.	astic surgery consult at the hospital date as found to be septic (the body's extremith a thermal injury (occurs when energy the temperature of local tissue) with blue to his dementia. Resident #1 was almar crease; blisters of [NAME] 5th dige the bony core of the digits (fingers) of a bone of the finger); 2) 2nd degree buseveral bullae (large blisters on the skir webspace, hemorrhagic blister (when ever proximal (situated near) 4th and sological confused and unable follow continue management of burn per proximal (situated near) 4th and sological confused and unable follow continue management of burn per proximal (situated near) 4th and sological confused and unable follow continue management of burn per proximal follow continue follow continue management of burn per proximal follow continue follow contin	ne response to an infection-life y is transferred from a heat source listers on his left hand and fingers. assessed as, 1) 2 Palmar (palm of git (finger) over phalanges (the the hand), blister on 4th digit rns of the dorsal (top) wrist and that are filled with clear fluid) blood pools and forms a blister) in 5th digit, bulla of 4th digit middle nmands or provide history. The stocol; recommend daily dressing exertix wrap and to keep hand the hospital at the time of the was sent to the hospital because and talked to the critical care hospital burned or abused. The DON then do told her it was a skin issue, not and mowed her phone of Resident #1's did not visit Resident #1 in person pointure that she took of Resident photo at that time. The DON said y, was when Resident #1 was sent tion, I think, the DON said she did as not interviewable and not talk at all. The DON said and he was bed bound and nily visitors. The DON said a burn and around the edges it would be leaking out from the edge of the to 3rd degree. She said what said an incident report was not done or injury. She said a wound care ours. The DON said, I know it is not en fluid filled blisters like that, that body. She said the blisters were the said Resident #1 could not tell
	(continued on next page)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/17/2022
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	D CODE
Immanuel's Healthcare	.r.	4515 Village Creek Rd Fort Worth, TX 76119	FCODE
For information on the nursing home's	plan to correct this deficiency, please con	l tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety	An interview with MDS RN F on 07/27/22 at 3:15 PM revealed the hospital critical care RN had called to find out what happened to Resident #1's hand and said his whole hand was burned. MDS RN F did not know details about it, so she read the progress notes to the hospital critical care RN and then told the DON about the call because the hospital RN sounded disbelieving. An interview with LVN B on 07/28/22 at 10:51 AM revealed she did not see Resident #1 over the weekend of		
Residents Affected - Few	07/23/22 and 07/24/22 but did see him when she arrived at work on Monday 07/25/22. LVN B said his skin was clear when she left work on Friday 07/22/22 but when she came back on 07/25/22, he had one big blister on the top of his left hand that had already busted and the night nurse (LVN A) was not sure what it was and no one could understand how he got blisters like that. LVN B said she did not know if it was a bur because something real hot would have had to caused it. She said Resident #1's index finger was really swollen and he had a blister on the pointer finger side going towards the thumb. LVN B said Resident #1 normally could talk, but he was not there at all, she shook him, called his name and tried to open his eyes get a reaction, but he was not responding, which was unusual. She said he could not tell her if he was in pain. She said by that time, the overnight nurse (LVN A) had notified the DON and physician to see what they wanted to do and MD E said to send him out since no one knew what had happened. LVN B said afte that, she googled burn blisters on the hand and the pictures on the internet looked like Resident #1's. LVN said, But I don't want to say it is a burn, because that is not good.		
	A follow up interview with MDS RN F on 07/28/22 at 11:17 AM revealed she had been employed at the facility for a month and she was the RN manager on duty on Sunday 07/24/22 and had come to the facilitiast in the morning around 11 AM. She said she had not been notified of any issues related to Resident # but as the MOD, she went to each nurses' station, asked how things were going, ask if there were any ne incidents and accidents and she was told no. She then went to the MDS office and did assessments and later helped serve dinner. She said she did not see Resident #1's hand. MDS RN F said she was first ma aware of Resident #1's hand during the morning management meeting on Monday 07/25/22, after he had already been sent out. She said, A nurse cannot diagnose and did not diagnose, that is why the doctor we called. That was [MD E]. MDS RN F said she did not know if MD E diagnosed Resident #1 but he ordered the treatment. She did not know what kind of treatment MD E ordered and said she was not the front line nurse. (continued on next page)		
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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. Building	COMPLETED
	676052	B. Wing	08/17/2022
NAME OF PROVIDER OR SUPPLIE	NAME OF PROVIDER OR SUPPLIER		P CODE
Immanuel's Healthcare		4515 Village Creek Rd Fort Worth, TX 76119	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with the overnight nurfacility Saturday 2pm-10pm and the overnight shift 10 PM-6 AM. LVN A overnight shift was over Sunday mhis skin and she wanted LVN A to blister right on top of his hand that draining. She said the skin was still dry dressing and put it on the 24 hc LVN A said she did not contact MD Resident #1's left hand injuries bed just cleaned it and wanted the wou normally work the weekends and the alert the oncoming nurse to follow the early morning before the wound that day for her overnight shift (Sur looked at the dressing, it looked like the amount of new blisters around so the blisters tripled in numbers in cleaned it, wrapped his hand with a as I know, there was nothing that he and told him about it for the first is send Resident #1 to the ER in case don't know if he was reacting to amburn because no one had mentione with the wound wrapped up, I don't Observation and record review of the O7/23/22 or 07/24/22 related to the An interview with the wound care Leaned in the she arrived at work Monday 0'talking about it conversationally in depending on the degree of it. She to the degree, and some skin may burns were blistered and a burn cosaid she would typically treat a burn said she would typically treat a burn said she would typically treat a burn said she would typically treat a burn cosaid she would typically treat a burn said said she would typically treat a burn said said said said said said said the said said said said said said said said	see, LVN A, on 07/28/22 at 11:56 AM rese overnight shift (07/23/22) and on Sunt a said she was notified by a CNA D in the prining (07/25/22) that the CNA was geook at it. When LVN A went to his roomed had popped and little one right next to on so she did not want to aggressively our report to remind herself. LVN A said E or an on-call doctor on Sunday 07/2 ause the facility lets the treatment nurse and nurse to look at it when she came in that was why she made a note in the 24 up. However, she said Resident #1 was did care nurse could look at his hand. What and the entire hand, like big, huge blisters was the entire hand, like big, huge blisters was at burned him, but the wound was grown and the would refer to be he had something contagious since it by thing or if he was burned. LVN A said ad anything to her, But with the tripling know.	vealed she had worked at the day (07/24/22) she worked the ne early morning hours before the ting him up and noticed issues with n, Resident #1 initially had a big it that had not popped but one was you it and she covered it with a different time. It is a different to the ER the next day in the LVN A came back to work later she was rounding and when she she unwrapped it, there were triple which were not there the day before of his hand. LVN A said she ingher what to do. She said, As far wing. At that point, she called MD a dermatologist, but then said to came on that rapidly. LVN A said, I she did not initially think it was a of them (the blisters) the next day, ##1's hall) revealed no entries on PM revealed that Resident #1 had tayle2-07/24/22. She said no one been sent to the hospital by the bout it through hearing people burn could present differently, ation, redness, some swelling due rn. She said most second degree me back up. Wound care LVN Got order. She stated, There is a lot of

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/17/2022
NAME OF PROVIDER OR SUPPLIE	ER	STREET ADDRESS, CITY, STATE, ZI	P CODE
Immanuel's Healthcare		4515 Village Creek Rd Fort Worth, TX 76119	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	07/22/22 and his skin looked great, Monday morning 07/25/22, she was CNA C said then the overnight nurs of his hand. She said she was wonhis hands balled up and only move looking like person who got burned and that he had blisters everywhere because he was blind and only spo C said, I said y'all sure it not a burn what if this is your family member? but did not give names. She said w But nothing, like he was losing it. C schedule who had worked with Res looked at me. She said, If it was my An interview with the DON on 07/25 physician to have he/she assess Rout to the hospital. She also stated she believed MD E was notified about to the hospital. She also stated she believed MD E was notified about to see what his orders were. She sishe did not call him. The DON said 7AM because she had to swab him been notified. When she went to his he had no indicators of pain and the said she did not tell LVN A to contate DON said that she was the RN in the arrived later that day and took over she had since started an in-service condition. She said when a change the change, complete an SBAR and there was an order given, to follow	she could see his hands when she lais stold that he maybe had an infection bee, LVN A took off the dressing and she dering how that could have happened dithem to itch his face. CNA C describe, because she had never seen an infection on his fingers and palm. Resident #1 ske a few words and he was not resport and they were like shhhhh (be quiet show they were like shhhhh (be quiet show the CNA C said she was asking various nithen Resident #1 was not responding to the Resident #1 before that time frame just in yfamily member, I would want to know as a scient #1 before that time frame just in yfamily member, I would want to know as a scient #1 before that time frame just in yfamily member, I would want to know as a scient #1 before that time frame just in yfamily member, I would want to know as sident #1 before that time frame just in yfamily member, I would want to know as sident #1 hand injury because the facility that day, arriving early in the ID-19 due to a recent positive case. She first saw Resident #1' hand when to test for COVID19. LVN A had alread she had just assumed LVN A called she facility that morning and the manager. She said MDS RN F did not see Resi with the nursing staff on 07/28/22 about in condition occurred with a resident, and make sure the resident is stable, call it up with any further charters. The bid was standard the there charters are the property to	d him down. When she saw him ecause his hand was wrapped. It is saw he had pink raw skin on top because Resident #1 always kepted Resident #1's left hand as stion that took the skin off like that could not tell her what happened isive, which was not normal. CNA ound) at the same time I was like urses and management about it, to her, she tried to do a sternal rub thould take staff members off the case, and investigate, and she just the facility is looking into it. If not contact the wound care he resident had already been senting on the weekend. The DON said rior to her arriving at the facility by morning around 6am because she said thought LVN A notified MD do not follow up with her afterward at MD E and she had no idea why she arrived that morning around dy seen his hand and the DON had hand before they erupted. She sat ther than his left hand. The DON to she had already done that. The er on duty was MDS RN F who dent #1's left hand. The DON said the word is left hand. The DON said ut how to identify a change in she expected the nurses to identif the physician and family and if the N said she initiated that in-service.

(continued on next page)

assumed he had already been called.

training because there was no order for Resident's treatment given to his left hand. The DON said she saw that LVN A treated it, but there was not an order for it. She had not yet in-serviced LVN A. However, the DON also admitted that she was the one who told LVN A what type of dressing to use, based on facility standing orders for basic issues like blisters and skin tears and that she did not want to put a cream or ointment on it, just a non-adhesive dressing wrapped in Kurlex. The DON said, If it was a burn, I would have sent him out to the hospital. With burns, we typically don't treat initial burns on the skin. We would wash under cold water and apply Silverdine maybe, but it's whatever the doctor would choose. A copy of the facility standing orders for basic skin treatment was requested but never provided. The DON said a nurse was not supposed to diagnose a resident, they can describe the situation to the physician. She said she did not talk to MD E on Sunday 07/24/22 so she did not describe Resident #1's skin change/injury to him, I

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/17/2022
NAME OF PROVIDER OR SUPPLIER Immanuel's Healthcare		STREET ADDRESS, CITY, STATE, ZI 4515 Village Creek Rd Fort Worth, TX 76119	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	AG SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	time on Resident #1's hall on Satur with him on another hall. She said he was quiet and she was worried She said he was a typically a heavy on him, he was dry up until 3:50 AM not as much as it used to could be all her shift until then. When she ch and he was laying on his hand so shown layer of something next to his hand and saw the entire left layer of up his hand and he groaned when LVN A and asked what happened the being in water too long but he was were huge blisters all over his hand unknowingly, so she told LVN A. Cor move his arms more than to his himself. She said LVN A wrapped if Resident #1 did seem to be in pain hand up and started to wipe it down like LVN A was not being responsive of her before and pass away, so Remove, cannot do this to themselves she (LVN A) wrapped his hand too, was like, just dry gauze on the open her the rest of the shift and CNA D that nurse again or on that hall. CNA interview with MD E on 07/28/22 attending physician to Resident #1 morning on 07/25/22 and they were Pox going on. He said the facility her for and he did not want it to get loot the facility mentioned it could have on Sunday 07/24/22 for a change in should have notified me for sure. I sam not sure if the nurses are sure of sent a photo of Resident #1's hand MD E said he would consider some indications of what caused the injur Resident #1 had burns on his hand	22 at 3:58 PM revealed she had worke day-Sunday shift (07/23/22-07/24/22), on that overnight shift, around 3:50 AM he was not breathing but then looked by soil and outputs a lot and the entire of a sign of the body shutting down. She stanged him, it was only urine and it could the turned him over. When CNA C turn im. She did not know what it was. She of skin on his left hand was missing. She I lifted it up and it looked like he had be because it looked fresh because his fine. African American. She said Resident #1 and fingers. CNA C said she had pick NA C said Resident #1 was severely in face, he was stuck in the fetal position his hand temporarily because there was not before it was wrapped, he was making and CNA C was panicked because she sesident #1's hand made her emotional. So I try not to freak out but there was not she didn't clean it, just put on a gauze on flesh, it will stick when you take it off. I later talked to the DON about her concluded a D said the DON did not make any included a saking him about the lesions he had we add no cases of Monkey Pox but it was seein the facility, so he wanted Resident he was in the facility, so he wanted Resident her condition. MD E said, If a resident has would have needed a description of the of what they are looking at or seeing. Mon 07/25/22 and that was the reason heating an injury of unknown origin is the ry and could not identify any infections I and any skin was inflamed underneating	but she knew him from working, she went in to check on him and loser and saw his chest was rising. ight when she would go and check continence being not as frequent or said Resident #1 had not voided at Id fill her palm so it was not much ed him over, there was a thin picked it up and then looked at this e said, I was like oh my god, I lifted sen burned. CNA C then went to gers where white in color, like of the had was soggy and there are dup the piece of his hand skin jured and he could not walk, see, and he could not have burned as puss on his hand. CNA C said aid when she and LVN A pulled his golittle groans. CNA D said she felt she had residents get hurt in front She said, Someone that cannot sense of urgency or care. When pad and wrapped it real quick. I CNA D said LVN A did not talk to the said, Someone that cannot sense of urgency or care. When pad and wrapped it real quick. I CNA D said LVN A did not talk to the said and the second with the said on one from the second which was a big deal with Monkey number one on his list to watch out at #1 sent out. He said no one from the when the injury was first identified as big blisters all over his hand, they be lesions. He said, A lot of times, I ID E said he remembered being the sent him out, when he saw it. It facility did not have any or inflammatory issues. He said it if not it, he would want to use

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/17/2022
NAME OF PROVIDER OR SUPPLIER Immanuel's Healthcare		STREET ADDRESS, CITY, STATE, Z 4515 Village Creek Rd Fort Worth, TX 76119	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informat	ion)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	which was caused by heat, but the #1's skin on the top of his left hand course of ABX for sepsis and UTI to focusing on presently. She said what internist but would contact the doct the doctor from the plastic surgery/ thermal burn. She said that doctor admission and they wanted to know infection. However, when the doctor suspicion that the infection caused the burn as thermal. She said there usually caused by an external heat An observation and attempted interhospital room. Resident #1's eyes questions. Upon increasing the voluquestions. Upon increasing the voluquestions were minimal, with only range 178/93, pulse 58. The hospital RN did not wince or make any motions healing. There were no more liquid blisters were and on his palm of his had grown back over the top of his There were no open areas noted.	or Resident #1 on 08/15/22 at 3:05 pm attending would be able to state that was growing back and doing much be but his blood pressure remained very hile at the hospital, he had contracted conding hospital physician on 08/15/22 for who completed the burn evaluation. Wound department on 07/26/22, who could a plastic surgery evaluation because wif the blistering/burn on the left hand for completed his assessment/evaluation the burn, and the sepsis most likely care were different categories of burns, but source. She said he was an internist surview of Resident #1 occurred on 08/15 were closed but he was awake. He was ume of the voice, he stirred and movemaking a sound each time, no discernationally assessed to be shand and the top of his hand and in the hand, however, it was lighter in color to the hospital RN said it looked like Resid dripped down and around through his TED]	with certainty. She said Resident tter. She said he finished his igh, and that was what they were COVID-19. Let 3:12 PM revealed she was an She said Resident #1 was seen by letermined Resident #1 had a see Resident #1 was septic at could have been caused by the n, he determined there was low the light was septically at a thermal burn was one that was so her specialization was not in skin. Let 3:30 PM while he was in his is initially not responsive to the light head, but his responses to able words. His blood pressure was the a dressing change. Resident #1 was observed to be in a state of the seen on his knuckles where the ne webbing of his fingers. The skin han the other surrounding skin.